KIENOL
CHIROPRACTIC

Confidential

NEW PATIENT FORM

Date: _____/_____/_____

Full Legal Name: _____ Date of Birth: _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

Employer: _____ Job Title: _____

Employer Address: _____

Marital Status: _____Married _____Single _____Widowed _____Divorced

Email: _____

Name/Ages of children: _____

Spouse's Name: _____ Spouse's DOB: _____ Spouse's SSN:_____

Spouse's Occupation: _____ Spouse's Employer:_____

Names of Family members being treated at our clinic: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Who referred you to our office? _____

Circle the care you desire: Temporary relief Long term corrective Doctor Recommendation

Gender* _____Male _____Female Preferred Language: _____

Ethnicity* _____Hispanic/Latino _____Non Hispanic/Latino _____I decline to answer

Race* _____American Indian or Alaska Native _____Asian _____Black or African American
_____White (Caucasian) _____Native Hawaiian or Pacific Islander _____ Other
_____ I decline to answer

Smoking status* _____Every day _____Occasionally _____Former smoker _____Never

Smoking start date (Optional):_____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____/_____

**Required per federal guidelines*

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NEW PATIENT FORM – Child (Under 18)

Date: ____/_____/_____

Full Legal Name: _____ Date of Birth: _____

Street Address: _____ Home Phone: _____

City/State/Zip: _____ Cell Phone: _____

Social Security Number: _____ Gender*_____Male _____Female

Names of family members being treated at our clinic: _____

Emergency Contact Name: _____ Relationship: _____

Phone:_____

Who referred you to our office? _____ Preferred Language: _____

Ethnicity* _____Hispanic/Latino _____Non Hispanic/Latino _____I decline to answer

Race* _____American Indian or Alaska Native _____Asian _____Black or African American

_____White (Caucasian) _____Native Hawaiian or Pacific Islander _____ Other

_____ I decline to answer

Does child live with: _____Both parents _____Father _____Mother

Mother's Name: _____ Work/Cell phone: _____ - _____-_____

Mother's DOB: _____/_____/_____ Social Security # _____-_____-_____

Occupation: _____ Employer:_____

Father's Name _____ Work/Cell phone _____ - _____-_____

Father's DOB: _____/_____/_____ Social Security # _____-_____-_____

Occupation_____ Employer _____

Please note the care you desire: _____Temporary relief _____ Long term corrective
_____ Doctor Recommendation _____ Other_____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____/_____

**Required per Federal Guidelines*

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FEMALE Supplemental History Form

Date: _____/_____/_____

Full Legal Name: _____ Date of Birth: _____

Name of OB/GYN physician _____

Phone Number of Physician (_____) _____ - _____

Date of Last OB/GYN exam _____ Was a Pap smear done? ____ Yes _____ No

Were the results of your last OB/GYN exam and Pap normal? ____Yes ____No ____Unsure

Have you ever had a miscarriage? _____Yes _____No

Are you pregnant? _____Yes _____No

Is there a chance you might be pregnant? _____Yes _____No

Are you late with your menstrual period? _____Yes _____No

When did your last period begin? Date_____

Are you taking oral contraceptives? _____Yes _____No

Do you have an IUD? _____Yes _____No

Do you have irregular cycles? _____Yes _____No

Pregnancy & X-ray Warning

Although X-ray examinations are not performed at Kienol Chiropractic, SC at this time, I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that if there is a chance that I might be pregnant, the 10 days following onset of a menstrual period are generally considered to be the safest time for an x-ray examination.

With full understanding of the above, and believing that I am not currently at risk, I give the doctors of Kienol Chiropractic, SC the permission to perform an X-ray examination on me if they feel it is necessary.

Patient Signature: _____ Date: _____

KIENOL
CHIROPRACTIC

Consent for Use or Disclosure of Health Information

At Kienol Chiropractic, we are very concerned with protecting your privacy. The law requires us to give you this disclosure and please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your condition.
- We may have to disclose your information to another health provider or hospital if it is necessary to request additional information including (but not limited to) previous blood test and/or urinalysis results or treatment history.
- We may have to disclose your information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your information within our practice for quality control and other operational purposes.

We reserve the right to change our privacy practices as needed. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit disclosure of information

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing.

Your right to revoke authorization

You may revoke any of your authorizations at any time, however the revocation must be in writing. The revocation will become active the date it is received. If you were required to give an authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Appointment Reminders

The doctors and/or members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, return any phone calls, or any other information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with those reminders or information and to leave messages on your answering machine or with individuals at your home or place of employment.

I have read the consent policy and agree to its terms. I am also acknowledging that I can receive a copy of this form (if I so request one).

Patient's Printed name: _____

Patient or Guardian Signature: _____ Date: _____

Relationship of Guardian to Patient: _____

Provider Representative: _____ Date: _____

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CHIROPRACTIC

Informed Consent

The primary treatment used by doctors of Chiropractic is the spinal adjustment. The doctors of Kienol Chiropractic, SC will primarily use that procedure to treat you.

The nature of the chiropractic adjustment

The doctors of Kienol Chiropractic, SC will use their hands or mechanical device upon your body in such a way to move your joints. That may cause an audible “pop” or “click”, much as you have experienced when you “crack” your knuckles. You may feel or sense movement.

The material risks inherent in chiropractic adjustment

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, and costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and potential x-ray. Stroke has been the subject of tremendous disagreement within and outside the profession with one prominent authority (Dr. Scott Halderman, DC, MD) saying that there is **at most** a one-in-a-million chance of such an outcome. Since even that risk should be avoided, if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as “rare”.

Ancillary treatments

In addition to chiropractic adjustments, the doctors of Kienol Chiropractic, SC may choose to use physiotherapy to aid your body in healing. Physiotherapy may include hot/cold packs, high/low frequency current, diathermy, ultrasound, electric muscle stimulation, interferential, massage/instrument assisted soft tissue therapy, vibration, and/or traction. These treatments, if used, do not involve any additional significant risks.

The availability, nature, and risk of other possible treatment options

Other treatment options for your condition includes:

- Self administered, over-the-counter analgesics and rest
- Medical care with prescription drugs such as anti-inflammatory, muscle relaxants, and painkillers
- Hospitalization with traction
- Surgery

Overuse of over-the-counter medications produces undesirable side-effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient’s general health, severity of the patient’s discomfort, the patient’s pain tolerance and self discipline in not abusing

the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain-killers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, the patient's pain tolerance and self discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks – some with rather high probabilities.

Hospitalization in conjunction with other care bears additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risks inherent in surgery includes adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The risks and dangers attendant to remaining untreated

Remaining untreated allows the formation of adhesions and reduces the mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have, myself, decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: _____/_____/_____

Patient's Printed Name: _____

Patient's Signature: _____

Name of Parent/Guardian (if applicable):_____

Signature of Parent/Guardian (if applicable):_____

KIENOL CHIROPRACTIC

HEALTH HISTORY FORM

Name_____ Sex _____M _____F Age_____

List and date ANY surgeries:_____

List and date ANY accidents or serious injuries:_____

List and date ANY broken bones or dislocations: _____

List and date ANY diagnosed diseases:_____

Family Physician_____ Phone (____)_____

Date of last physical exam_____ By whom?_____

Have you ever had: _____Spinal X-ray(s) _____MRI _____ CAT scan

If yes, when? Where?_____

CURRENT COMPLAINTS / SYMPTOMS:

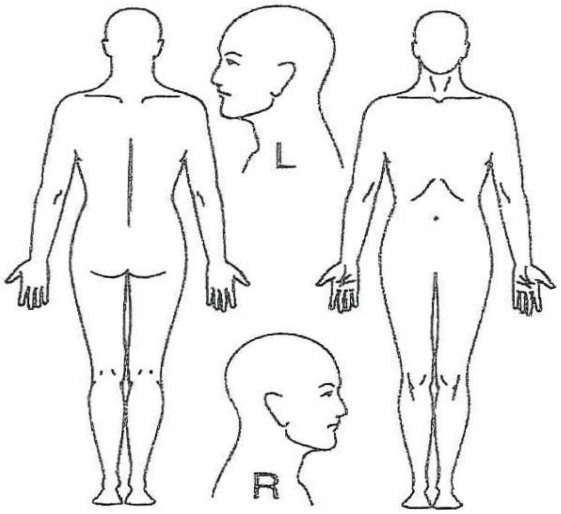
When did you first notice the problem?_____

What do you think caused the problem?_____

Describe the problem (Be as specific as possible):_____

Mark the areas on this body where you felt the described sensations. Use the appropriate symbols in all affected areas.

Numbness	**xxxxxxxx**	The Problem:	
Pins & Needles	**.....**	Comes and goes	Is constant
Burning	**oooooooo**		
Aching	**vvvvvvvv**	The problem came on:	
Stabbing	**IIIIIIIIIIIIIII**	Gradually	Suddenly



PAIN LEVEL: On a scale of 1-10, with 0 being you're pain free and can function quite well, and 10 being you're in very severe pain and cannot function at all, where would you rate yourself? (Place an X on the line.)

0 1 2 3 4 5 6 7 8 9 10

NO PAIN VERY SEVERE PAIN

What activities, positions, or movements make the problem ***worse***?_____

What activities, positions, or movements make the problem ***better***?_____

Have you ever had this problem before? ____Yes ____No If yes, when?_____

Have you ever had chiropractic care before? ____Yes ____No If yes, when?_____

For what problem(s)_____ How long_____

Have you ever consulted a medical physician for this problem? ____Yes ____No

If yes, who?_____ When_____

Length of Care_____ Diagnosis_____ Treatment_____

Are you currently taking any medications?	Include regularly used over the counter medications
Medication Name	Dosage & Frequency

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Coments

Family Medical History (Record one diagnosis in your family history and the affected)

Diagnosis (Write in below)	Father Alive: ☐YES ☐NO	Mother Alive: ☐YES ☐NO	Sibling: How many: _____	Offspring: How many: _____
Example: heart disease				

INDICATE HABITS: ☐ Smoking, _____pks/day ☐ Alcohol, _____ drinks/day ☐Coffee, _____ cups/day

CIRCLE ALL SYMPTOMS YOU CURRENTLY HAVE AND **UNDERLINE** ANY YOU HAVE HAD

GENERAL SYMPTOMS
Headaches
Fevers
Chills
Night sweats
Fainting
Dizziness
Convulsions
Fatigue
Nervousness
Loss of weight
Allergies
Hernia
Weakness
Twitching
Swollen Joints
Tremors
Swollen joints
Tremors

GASTRO-INTESTINAL
Poor appetite
Excessive hunger
Belching or gas
Nausea
Vomiting
Pain over stomach
Constipation
Diarrhea
Hemorrhoids

SKIN
Itching
Bruise easily
Eczema

CARDIOVASCULAR
Rapid heart rate
Slow heart rate
High blood pressure
Low blood pressure
Pain over heart
Heart trouble
Swelling of ankles
Poor circulation

RESPIRATION
Chronic Cough
Spitting blood
Chest pain
Difficulty breathing

EYE/EAR/ NOSE/THROAT
Poor vision
Crossed eyes
Poor hearing
Earache / Infection
Ringing in ears
Nose bleeds
Sore throat / hoarseness
Asthma

GENITO-URINARY
Frequent / painful urination
Frequent / painful urination
Blood in urine
Inability to control urination
Prostate trouble
Male/Female reproduction

Please list ANY other health problems or symptoms not covered:_____

_____