KC CHIROPRACTIC
17 WOODLAND ROAD
MADISON, CT 06443
(203) 245-9317

CONFIDENTIAL INTRODUCTORY PATIENT INFORMATION

DATE_____

NAME_____SS#_____

HOME #_____ CELL #_____

EMAIL_____

ADDRESS_____

CITY _____STATE _____ ZIP _____

AGE _____ SEX _____ BIRTHDATE _____ MARITAL STATUS: S M W D

NAME OF SPOUSE _____# OF CHILDREN _____AGES _____

OCCUPATION _____ EMPLOYER _____PHONE# _____

EMERGENCY CONTACT_____ PHONE # _____

WHOM MAY WE THANK FOR REFERRING YOU _____

PRESENT HEALTH PROBLEM _____

MARK WITH **"X"** IF RELATED TO YOUR CHIEF COMPLAINT OR "\" IF A SECONDARY SYMPTOM:

NECK
( ) DULL PAIN
( ) PAIN WITH MOVEMENT
( ) FEELS OUT OF PLACE
( ) SWELLING IN NECK
( ) MUSCLE SPASMS
( ) GRINDING SOUNDS
( ) POPPING SOUNDS
( ) STIFF NECK
( ) LIMITED MOVEMENT
( ) PREVIOUS HEAD/NECK INJURY
( ) NONE

SHOULDERS
( ) SHOULDER PAIN (R/L)
( ) PAIN ACROSS SHOULDERS
( ) TENSION IN SHOULDERS
( ) MUSCLE SPASMS
( ) DIFFICULTY RAISING ARMS
( ) NONE

HIPS/LEGS/FEET
( ) PAIN IN BUTTOCKS
( ) PAIN DOWN LEG
( ) KNEE PAIN
( ) LEG CRAMPS
( ) PINS & NEEDLES
( ) ANKLE PAIN
( ) HIP PAIN
( ) NONE

LOW BACK
( ) LOW BACK PAIN
( ) SHARP
( ) DULL
( ) LOCALIZED
( ) RADIATES
( ) FEELS OUT OF PLACE
( ) MUSCLE SPASMS
( ) NONE

MID BACK
( ) MID BACK PAIN
( ) PAIN B/W BLADES
( ) SHARP STABBING PAIN
( ) DULL ACHES
( ) PAIN OVER KIDNEY AREA
( ) MUSCLE SPASM IN MID BACK
( ) PAIN WITH BREATHING OR SNEEZING
( ) NONE

ARMS AND HANDS
( ) LOSS OF GRIP STRENGTH
( ) PAIN IN ELBOW
( ) HANDS COLD
( ) JOINT STIFFNESS
( ) PAIN IN HANDS
( ) PAIN IN FOREARM
( ) PINS & NEEDLES
( ) NONE

KC CHIROPRACTIC

WHEN DID YOUR CHIEF COMPLAINT FIRST APPEAR? _____

IS IT GETTING WORSE, STAYING THE SAME OR GETTING BETTER? _____

WHAT RELIEVES IT? _____

WHAT MAKES IT WORSE? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS CONDITION? _____

_____

NAME OF FAMILY PHYSICIAN _____ PHONE # _____

ARE YOU TAKING MEDICATIONS? ____ IF YES, PLEASE LIST_____

WHAT SURGERIES HAVE YOU HAD? _____

HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE BEFORE? _____ WHEN? _____

NAME/ PHONE # OF CHIROPRACTOR _____

HAVE YOU HAD ANY SERIOUS INJURIES OR BROKEN BONES (WHETHER BY CAR, MOTORCYCLE,

SPORT,ETC.?) SPECIFY DATE _____

IN WHAT ACTIVITIES ARE YOU INVOLVED?_____

PLEASE LIST ANY ADDITIONAL INFORMATION TO HELP US TO UNDERSTAND YOUR CONDITION

_____

_____

SOCIAL HISTORY (CHECK ALL THAT APPLY):

( ) SMOKING _____
( ) OTHER TOBACCO USE _____
( ) ALCOHOL USE _____
( ) DRINK COFFEE / TEA _____
( ) NONE

RECREATION IS:
( ) SUFFICIENT
( ) NOT SUFFICIENT

REST IS:
( ) SUFFICIENT
( ) NOT SUFFICIENT

DIET IS:
( ) BALANCED
( ) NOT BALANCED

MY FAMILY STRESS IS:
( ) SEVERE
( ) MODERATE
( ) MINIMAL
( ) NONE

MY JOB STRESS IS:
( ) SEVERE
( ) MODERATE
( ) MINIMAL
( ) NONE

OVERALL I FEEL:
( ) IN GOOD HEALTH
( ) FATIGUE
( ) FEEL RUN DOWN
( ) READY TO "LOSE IT"

( ) NERVOUSNESS
( ) DEPRESSED
( ) CRAVE SWEETS

( ) IRRITABILITY
( ) MEMORY LOSS
( ) CRAVE SALT

KC CHIROPRACTIC

PLEASE "CHECK" THE CONDITIONS YOU HAVE HAD OR

"X" ITEMS MEMBERS OF YOUR FAMILY HAVE HAD:

( ) AIDS
( ) ANEMIA
( ) ARTHRITIS
( ) CANCER
( ) CARDIAC
( ) HYPOGLYCEMIA
( ) MULTIPLE SCLEROSIS
( ) PARKINSON'S DISEASE
( ) POLIO
( ) RHEUMATIC FEVER
( ) TUBERCULOSIS
( ) VENEREAL DISEASE
( ) STROKE
( ) DIABETES
( ) OTHER _____

_____

SKIN /HAIR /NAIL:
( ) ECZEMA
( ) DRY SKIN
( ) OILY SKIN
( ) BRUISE EASILY
( ) PAPER THIN NAILS
( ) BITES NAILS
( ) ITCHING
( ) DANDRUFF
( ) SMALL BLISTERS
( ) ACNE
( ) NONE

EYES/EARS/NOSE:
( ) LIGHT BOTHERS EYES
( ) VERTIGO
( ) RINGING IN EARS
( ) FREQUENT COLDS
( ) SINUSITIS
( ) NASAL ALLERGIES
( ) BITTER/METALLIC TASTE
( ) GLAUCOMA
( ) CATARACTS
( ) NOSE BLEEDS
( ) NONE

CARDIOVASCULAR:
( ) GENERAL SWELLING
( ) SWELLING IN LEGS
( ) RAPID HEART BEAT
( ) HYPERTENSION
( ) HIGH BLOOD PRESSURE
( ) STROKE
( ) HEART ATTACK
( ) ANGINA
( ) NONE

RESPIRATORY:
( ) SHORTNESS OF BREATH
( ) DRY COUGH
( ) PRODUCTIVE COUGH
( ) WHEEZING
( ) FREQUENT SIGHING/ YAWNING

GENITOURINARY:
URINATION IS:
( ) FREQUENT
( ) NORMAL
( ) PAINFUL

GASTROINTESTINAL:
( ) CAN'T EAT SOME FOOD
( ) ABDOMINAL PAIN
( ) CHANGE IN BOWEL HABITS
( ) DIARRHEA
( ) CONSTIPATION
( ) HEMORRHOIDS
( ) BLOATING
( ) SPASTIC COLON
( ) NONE

HEADACHES:
( ) OFTEN
WHERE?
_____
FOR HOW LONG?
_____
( ) RARELY
( ) NONE

VENEREAL DISEASE:
( ) AIDS
( ) SYPHILIS
( ) GONORRHEA
( ) HERPES
( ) NONE

WOMEN ONLY:
( ) PAINFUL PERIODS
( ) PMS
( ) LUMPS IN BREAST
( ) PREGNANCY
HOW MANY? _____
DELIVERIES _____
( ) ARE YOU PREGNANT NOW: Y N DUE DATE

( ) MENSES CYCLE
( ) HEAVY
( ) LIGHT
( ) LONG DURATION
( ) SHORT DURATION
( ) MENOPAUSE
( ) TAKING BIRTH CONTROL

KC CHIROPRACTIC
INTRODUCTORY PATIENT INFORMATION

CONSENT TO TREAT/WAIVER OF X-RAYS

I DO NOT FEEL THAT MY PRESENT PROBLEM OR ILLNESS IS SERIOUS ENOUGH TO WARRANT THE USE OF X-RAYS *AT THIS TIME* SO THAT A COMPLETE STUDY AND ANALYSIS CAN BE MADE BY YOU.

THEREFORE, YOU ARE HEREBY AUTHORIZED AND DIRECTED TO TREAT MY PRESENT PROBLEM OR ILLNESS.

SHOULD ANY UNTOWARD EFFECTS OR ANY FURTHER ILLNESS OR INJURY DEVELOP, DIRECTLY OR INDIRECTLY, AS A RESULT OF SUCH TREATMENT, I SHALL ASSUME FULL RESPONSIBILITY. IN CONSIDERATION OF YOUR TREATING ME AT MY REQUEST WITHOUT BENEFIT OF A COMPLETE STUDY AND ANALYSIS, I HEREBY RELEASE YOU FROM ALL CAUSES OF ACTION, DAMAGES, AND LIABILITIES ARISING BY REASON OF SAID TREATMENT, WHETHER HERETOFORE OR HEREAFTER OCCURRING, AND WHETHER NOW KNOWN OR UNKNOWN BY THE PARTIES HERETO.

SIGNED: _____

DATE: _____

WITNESS: _____

KC CHIROPRACTIC
INSURANCE PORTION AGREEMENT

I UNDERSTAND AND AGREE THAT MY HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN MY INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THE OFFICE OF KC CHIROPRACTIC WILL ASSIST MY INSURANCE COMPANY IN THE FILING OF MY CLAIM, WHICH I MAY SUBMIT, AND THAT ANY DUPLICATE AMOUNT INADVERTENTLY PAID DIRECTLY TO THE OFFICE OF KC CHIROPRACTIC WILL BE CREDITED TO MY ACCOUNT AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT, BOTH FOR SERVICES WHEN RENDERED AND **$80.00 FOR MISSED APPOINTMENTS IF I FAIL TO GIVE TWENTY-FOUR (24) HOURS ADVANCE NOTICE OF MY CANCELLATION.** I ALSO RECOGNIZE THAT I MAY BE RESPONSIBLE FOR CHARGES IN addition TO MY COPAY AND DEDUCTIBLE FOR CHARGES MEDICALLY NECESSARY THAT ARE NOT COVERED BY MY INSURANCE. SUCH CHARGES WILL BE BROUGHT TO MY ATTENTION BEFORE TREATMENT IS RENDERED. I HERBY AUTHORIZE THE OFFICE OF KC CHIROPRACTIC TO RELEASE ANY INFORMATION RELATED TO THE DIAGNOSIS AND TREATMENT OF ME TO ANY INSURANCE AGENCY, ATTORNEY, ATTENDING PHYSICIAN OR EMPLOYER IN ORDER TO PROPERL Y ADMINISTER THE DISPENSATION OF MY CASE. I ACKNOWLEDGE THAT MEDICARE MAY NOT COVER THESE SERVICES.

I WILL BE PAYING BY ( ) CASH ( ) CHECK ( ) CREDIT CARD ( ) INSURANCE

Fill out below or submit insurance card.

Insurance Company

Phone Number/Address

Identification Number Group Number

Policy Holder

Deductible/ co-pay

I, _____ have read the above Insurance Portion Agreement, and am fully aware of, understand, and agree with its contents.

PATIENTS SIGNATURE DATE

PARENT/GUARDIAN SIGNATURE DATE
(if patient is a minor)

KC CHIROPRACTIC

New Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, KC Chiropractic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that KC Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that KC Chiropractic reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should KC Chiropractic change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail Of, in agree, email).

I wish to have the following restrictions to the use or disclosure of my health information: _____
_____
_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____
Patient Signature:

_____
Date: