Patient Information

Date _____

Patient _____

Address _____

City _____

State _____Zip _____

Sex ❑M ❑ F Age____Birthdate_____

❑Single ❑ Married ❑ Widowed
❑ Divorced _____ # of Children

Patient SS# _____

Occupation _____

Employer _____

Spouse's Name _____

Whom may we thank for referring you?
_____

Name of Medical Doctor _____
Facility _____
Phone _____

Phone Numbers

Home _____
Cell _____
Work _____
E-mail address _____
Best time to reach you _____

IN CASE OF EMERGENCY, CONTACT.
Name _____
Relationship_____
Phone _____
Work _____ Ext. _____

Insurance

Who is responsible for this account? ____
_____

Relationship to patient _____

Insurance Company _____
_____

Policy ID _____

Is patient covered by additional insurance?
❑ Yes ❑ No

Subscriber's Name (who is the policy holder) _____
Insured's SSN:_____
Insured's DOB: ____/____/_____
Relationship to patient
_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the company listed above and assign directly to Kenkel Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I *am* financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship Date

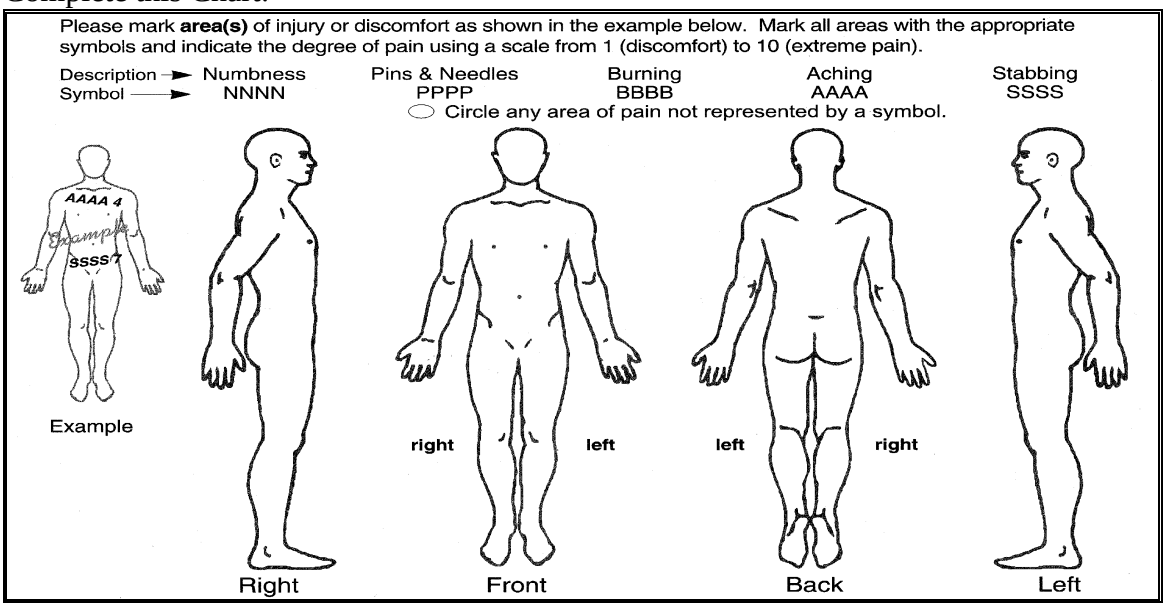
Accident Information

Is the condition due to an accident ❑Yes
❑ No Date_____
Type of accident ❑ Auto ❑ Work
❑ Home ❑ Other
To whom have you made a report of your accident? ❑ Auto Ins. ❑ Employer ❑ Work Comp. ❑ Other
Attorney Name (if applicable) _____
_____

Patient Information

Reason for your visit: _____
When did your symptoms start: _____
Is this condition progressively getting worse: ( )Yes ( )No ( )Same
How often do you have this pain/symptoms: _____
Does it interfere with your: ( )Work ( )Sleep ( )Daily Routine ( )Recreation
Movements that are painful to perform: ( )Sitting ( )Standing ( )Lying ( )Walking

Complete this Chart:



What treatment have you already received for your condition: ( ) Chiropractic ( ) Surgery ( ) Medication ( ) Physical Therapy ( ) None ( ) Other:_____
Name and address of other doctor(s) who have treated you for your condition:
_____

Date of last: Physical Exam_____Spinal X-ray_____
Spinal Exam_____ MRI, CT, Bone Scan_____

Current Medications	**Allergies**	**Vitamin/Herb/Minerals**

Exercise	***Well Balanced Diet***	***Alcohol Consumption***	***Tobacco Use***
( )Never	( )Never	( )Never	( )Never
( )Rarely	( )Rarely	( )Rarely	( )Rarely
( )Occasionally	( )Occasionally	( )Frequently	( )Frequently
( )Regularly	( )Regularly	( )Daily	( )Daily

WOMEN: Are you pregnant? ( )Yes ( )No ( )Trying to Conceive Due Date:_____

Injuries/ Surgeries in past **Description** **Date**

Falls/Injuries_____

Accidents _____

Surgeries/Illness_____

Family History: Do any of your family members suffer from any of the following:
__ Arthritis __ High Blood Pressure __High Cholesterol __Diabetes __ Depression
__ Heart Disease __ Cancer __ Chronic Pain __ Other: _____, _____

REVIEW OF SYSTEMS

Have you in the Past (P) or currently (C) suffer from any of the following symtoms/condtions?

General Symptoms	***Mental Health***	***Bowel/ Bladder***
Decreased Activity Level ___	Irritability ___	Frequent Urination ___
Fever ___	Depression ___	Urgency ___
Chills ___	Disturbed Sleep __	Trouble start or stopping ___
Fatigue ___	Suicidal Thoughts ___	Erectile Dysfunction ___
Night Sweats ___	Anxiety ___	Nocturia/Bedwet ___
Loss of Appetite ___	Nervousness ___	Burning with urination ___
Weight Loss ___		Losing control/incontinence __
Weight Gain ___		Bowel Dysfunction ___
Loss of Energy ___		Sexual Dysfunction ___

Vision	***Heart/ Lungs***	***Stomach***
Blurred Vision ___	Chest Pain ___	Nausea ___
Double Vision ___	Palpitations ___	Vomitting ___
Vision Loss ___	Fainting ___	Diarrhea ___
Eye Pain ___	Shortness of Breath ___	Constipation ___
Work Glasses/ Contacts ___	Ankle Swelling ___	
	Coughing ___	
	Wheezing ___	

Joint/ Neurological	***Skin***	***Immunity/ Endocrine***
Joint Pain ___	Rash ___	Enlarged Lymph Nodes ___
Joint Weakness ___	Itching ___	Hives ___
Muscle Weakness ___	Dryness ___	Hay Fever ___
Seizures ___	Lesions ___	Persistent Infections ___
Abnormal sensory Arm/ Leg __	Open Wound/ Infection ___	Diabetes ___
Loss of Memory ___	Hair/Nail Changes ___	Thyroid Disorder ___

Signature_____ **Date**_____

Doctor's Signature_____ **Date**_____

Kenkel FAMILY CHIROPRACTIC

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.
Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation Complex (VSC): A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Adjustment: The specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine using our hands or instruments depending on your individual needs.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. It you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom.** Our only method is specific adjusting to correct VSC.

PRIVACY POLICY

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive you medical records, please inform our office.

I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

Signature Date

Informed Consent to Chiropractic Treatment

The State of Iowa requires that every patient be informed of the risks of treatment and the alternatives prior to the beginning of treatment. The following is Kenkel Family Chiropractic's informed consent. We intend this consent form to cover the entire course of treatment for your present condition and for any future conditions for which you seek treatment at this or any other Kenkel Family Chiropractic clinic.

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to manipulate your joints. You may hear a "click" or a "pop", similar to when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or traction, as well as exercise instruction may also be used.

Possible risks and probability: There are inherent risks in any and all treatment delivered by any health care provider, ranging from taking a single aspirin to complicated brain surgery. Chiropractic is no exception. Although we take every precaution, there are indeed some slight risks to chiropractic manipulation. The risk is very minor to almost nonexistent in any treatment of extremities. The risks involved in treatment to the spine excluding the neck are several. A list from the least to most serious would include muscular strain (rare), ligamentous sprain (rare), fractures (rare), and injury to the intervertebral disks, nerves or spinal cord (very rare). The risk involved in the treatment of the neck would include any on the preceding list but also include the remote possibility of cerebrovascular injury, or stroke (very, very rare: chances are one in one million to one in ten million). A minority of patients may notice stiffness or soreness after the first few days of treatment (common). The ancillary physical therapy procedures could produce skin irritation, burns, or other minor complications (rare).

Other treatment options that could be considered may include the following:

Over-the-counter analgesics. The risks of these medications include irritation to the stomach, liver, and kidneys, and other side effects in a significant number of cases.

Medical care, typically anti-inflamatory drugs, tranquilizers, and analgesics. Risks of these drugs include numerous undesirable effects, usually more serious than those listed above and patient dependence in a significant number of cases.

Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia (which includes death), as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

Concerns or questions: Please ask your Doctor of Chiropractic. We at Kenkel Family Chiropractic have gone to great lengths to make your health and safety our top priority. We will be glad to explain any concern about treatment you might have. Suffice to say we will only recommend treatment for you that we would feel comfortable having performed on ourselves.

I have read the above explanation of chiropractic treatment. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____ _____ _____

Printed name of Patient **(Parent Signature if Patient is a Minor)** **Date**