

Welcome to Kraft Chiropractic

Infant Information

Date: _____

Name: _____
(Last) (First) (Middle)

Address: _____ City: _____

State: _____ Zip: _____ Gender: Male Female

Birth Date: ___/___/___ SS#: _____ Height: _____ Weight _____

Name of person responsible for this account: _____ Phone #: _____

Family E-mail Address: _____

Address of person responsible for this account: _____

Name of Father: _____

Does Father have any health problems? _____

Name of Mother: _____

Does Mother have any health problems? _____

Any difficulties with birth? _____

Any difficulties after birth? _____

Referred by: Another Patient (Name: _____)

Internet (_____) Other (_____)

Have you had chiropractic care before? Yes No

When? _____ Dr. Name: _____

Have you ever had any accidents, injuries, or major falls? Yes No

Major complaints: _____

Position of greatest pain: _____

Are you currently taking any medications and/or nutritional supplements? Yes No

Please use the symbols below to mark the area(s) upon the body outlines in which you are experiencing pain:

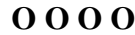
Numbness



Pins & Needles



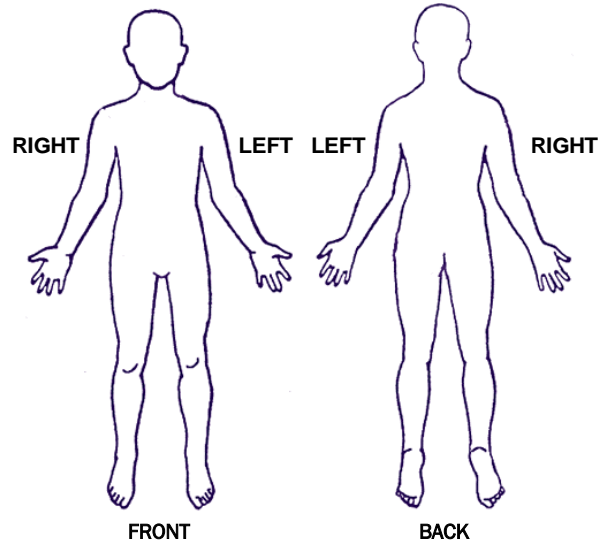
Burning



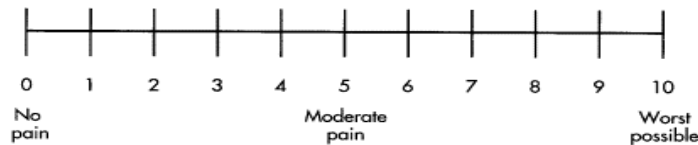
Aching



Stabbing



Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).



Insurance Information

Company Name: _____ Subscribers Name: _____

Relation: _____ Date of Birth: ____/____/____

Please note: We will gladly call your insurance to check your chiropractic benefits. However, per the insurance companies, it is the **patient's** responsibility to know their benefits and track visit limits. (You can inquire with receptionist as needed.) The benefits provided by your insurance company are **not a guarantee** of payment. Therefore, although we will file the claims with your insurance company, by signing this you agree that you are responsible for any unpaid portion of services rendered.

Parent/Guardian Signature _____ Date: ____/____/____

Acknowledgement of Receipt of Notice of Privacy Policy

I acknowledge that Kraft Chiropractic Clinic's Notice of Privacy Practices has been provided to me. I understand that I have a right to review Kraft Chiropractic Clinic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Kraft Chiropractic Clinic. The Notice of Privacy Practices for Kraft Chiropractic Clinic is also provided on request at the main administration desk of this practice and on Kraft Chiropractic Clinic's website at www.kraftchiro.org. This Notice of Privacy Practices also describes my rights and Kraft Chiropractic Clinic's duties with respect to my protected health information.

Kraft Chiropractic Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Kraft Chiropractic Clinic's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

Please check the appropriate box for any of the following symptoms, which you now have or have had previously. This is a confidential health report.

occasional
frequent

Muscle

- Arthritis
- Bursitis
- Foot Trouble
- Low back pain or stiffness
- Pain between shoulders
- Sciatica
- Swollen joint

occasional
frequent

Pain, Numbness, Tingling or Cramps

- Shoulders
- Arms
- Hands
- Hips
- Legs
- Knees
- Feet

occasional
frequent

- Lung Trouble
- Sinus Trouble
- Asthma
- Shortness of Breath
- High/Low Blood Pressure
- Heart Trouble
- Leg Cramps
- Varicose Veins

occasional
frequent

- Nausea/Indigestion
- Stomach Trouble
- Colon Trouble
- Constipation
- Joint Stiffness
- Paralysis
- Skin Rash
- Depression
- Headaches
- Dizziness

occasional
frequent

- Exhaustion
- Weakness
- TMJ
- Nervousness
- Crying Spells
- Worry
- Frequent Anger
- Fear
- Bad Dreams
- Poor Health

occasional
frequent

- Prostate Trouble
- Kidney Trouble
- Bladder Trouble
- Female Trouble
- Menstrual Cramps
- Nerve Pain
- Circulatory Issues
- Gallbladder Issues

Have your children had a scoliosis exam by a chiropractor? YES NO
 Are you interested in a free spinal/scoliosis exam for your children? YES NO

After reading and filling out the health history, your signature will verify that all the information you have given us is accurate and that you have read the health history questions entirely.

Parent/Guardian Signature: _____ Date: ____/____/____

OUR PERSONAL CONCERN

Our professional and personal concern is with just two things, your health and our reputation. Therefore, we accept only those patients whom we sincerely believe we can help.