KRAFT
Chiropractic Clinic

PATIENT FORMS

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

Address: _____ City:_____

State: _____ Zip: _____ Birth Date: _____ /_____ /_____ Gender: Male Female

Height: _____ Weight: _____ E-Mail Address:_____

Home # _____ Cell #_____

Cell Phone Carrier: AT&T Sprint T-Mobile Verizon Other_____

By listing the above information, I am agreeing to receive reminder/appointment messages via e-mail or text from Kraft Chiropractic Clinic.

Work # _____ Occupation:_____

Employed By:_____

Address: _____ City: _____ State: ___ Zip: _____

Person responsible for account: Self Spouse Parent Other:_____

Name: _____ Phone #:_____

Address: _____ City: _____State:____ Zip: _____

How were you referred to our office?

Another Patient_____ Internet _____ Other_____
(Patient's name) (Which site)

Do you desire: ❑ Maximum improvement ❑ Temporary Relief

Is this the result of an auto accident? YES NO

Is this the result of a work related injury? YES NO

FOR OFFICE USE ONLY:

Height_____ Weight_____ O2_____ BP_____ Pulse_____

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165 W Auburn Rd, Rochester Hills, MI 48307
(248) 299-2620
www.Kraftchiro.org

Payment Information

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.) **If you do not want your insurance billed and would prefer to pay out-of-pocket, please notify the receptionist immediately.** PLEASE BE AWARE THAT OUR OFFICE DOES NOT ACCEPT STRAIGHT MEDICAID INSURANCE. 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. Any balances due for services are due regardless of results.

Due to Medicare guidelines/policies we cannot offer any promotional discounts to Medicare patients.

Patient Signature: _____ Date: _____/_____/_____

Insurance Company: _____

Subscribers Name: _____ Relation: _____

Date of Birth: _____ /_____ /_____

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 time of my next appointment.

_____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative Description of Personal Representative's Authority

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the know benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic..

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand or a mechanical device where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

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. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare, it can be associated with other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

The doctor and/or his staff will not be held responsible for any health conditions or diagnosis's which are pre-existing, given by another healthcare practitioner, or are not related to the structural conditions diagnosed at the clinic.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic are have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____
Print Name Date

_____
Signature

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____
Print Name Date

_____
Signature

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle:_____

_____ _____
Print Name Date

_____
Signature

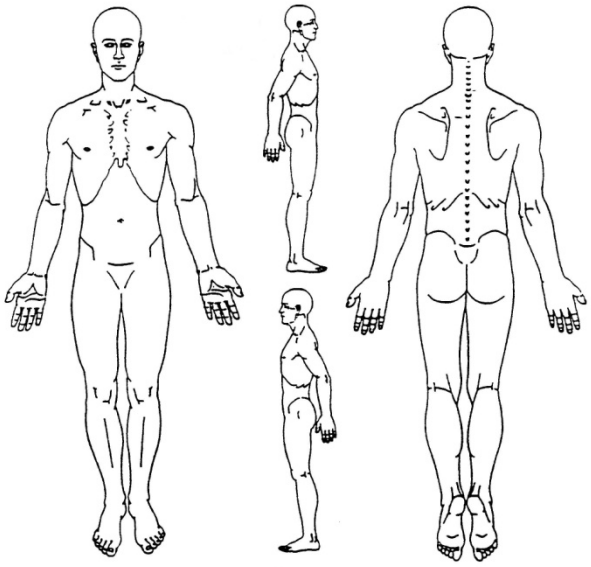
Patient Name:_____ **Date:**_____

SHOW US YOUR PAIN

Use the letters below to indicate the type and location of your symptoms today.

KEY

A = ache
S = stabbing
B = burning
X = stiffness
N = numbness
T = throbbing
P = pins & needles
O = other



Please list your present complaint(s) and indicate the level of pain today for each complaint - If you have more than one area of complaint list them in order of most severe to least severe.

PROBLEM 1: _____

Duration (approx. start date): _____

	BEST										WORST
Now:	0	1	2	3	4	5	6	7	8	9	10
On average:	0	1	2	3	4	5	6	7	8	9	10
At its best:	0	1	2	3	4	5	6	7	8	9	10
At its worst:	0	1	2	3	4	5	6	7	8	9	10

PROBLEM 2: _____

Duration (approx. start date): _____

	BEST										WORST
Now:	0	1	2	3	4	5	6	7	8	9	10
On average:	0	1	2	3	4	5	6	7	8	9	10
At its best:	0	1	2	3	4	5	6	7	8	9	10
At its worst:	0	1	2	3	4	5	6	7	8	9	10

PROBLEM 3: _____

Duration (approx. start date): _____

	BEST										WORST
Now:	0	1	2	3	4	5	6	7	8	9	10
On average:	0	1	2	3	4	5	6	7	8	9	10
At its best:	0	1	2	3	4	5	6	7	8	9	10
At its worst:	0	1	2	3	4	5	6	7	8	9	10

PROBLEM 4: _____

Duration (approx. start date): _____

	BEST										WORST
Now:	0	1	2	3	4	5	6	7	8	9	10
On average:	0	1	2	3	4	5	6	7	8	9	10
At its best:	0	1	2	3	4	5	6	7	8	9	10
At its worst:	0	1	2	3	4	5	6	7	8	9	10

What caused your problem (mechanism of trauma)? _____

How often are you experiencing it?

❒ Infrequently (Less than daily) ❒ Occasionally (1/4 of the time) ❒ Intermittently (1/2 of the time) ❒ Frequently (3/4 of the time) ❒ Constantly (90- 100% of the time)

What makes it worse? (check all that apply)

❒ Bending ❒ Looking down ❒ Weight bearing
❒ Coughing ❒ Sitting
❒ Lifting ❒ Standing
❒ Looking up ❒ Walking
❒ Other: _____

What makes it better? (check all that apply)

❒ Adjustments ❒ Hot baths ❒ Pain meds
❒ Bed rest ❒ Ice ❒ Resting
❒ Exercising ❒ Lying down ❒ Traction
❒ Heat ❒ Nothing ❒ Massage
❒ Other:_____

Describe any other symptoms related to this problem: _____

What have you done for this problem before coming in? (mark all that apply)

❒ Bed rest ❒ Massage ❒ Exercise ❒ Nothing ❒ Other _____
❒ Heat ❒ Pain Meds ❒ Hot Showers ❒ Topical Ointment
❒ Ice ❒ Traction ❒ Chiropractic ❒ Family MD

Difficulties with activities of daily living – Using a scale of 1-5, 1 being I can do it with no difficulty and 5 being I cannot do it at all because of the pain, rate your current difficulties resulting from your current accident/illness.

Getting Dressed_____ Walking_____ Sleeping_____ Self Hygiene_____
Climbing Stairs_____ Driving_____ Daily Chores_____ Bending_____
Social Life_____ Sitting_____ Lifting_____ Concentration_____
Standing_____ Exercising_____ Other_____

PREVIOUS ILLNESSES & MAJOR INJURIES – Please list any previous illnesses and major injuries:

Year _____ Type _____ Residual problem_____

Year _____ Type _____ Residual problem_____

Year _____ Type _____ Residual problem_____

SURGERIES & HOSPITALIZATION – Please list any surgeries and hospitalizations:

Year _____ Type _____ Residual problem_____

Year _____ Type _____ Residual problem_____

Year _____ Type _____ Residual problem_____

MEDICATIONS & SUPPLEMENTS – Please list all medication, nutritional supplements(s), vitamins (v), & over the counter drugs(OTC):

Medication _____ Milligrams/day _____ S.V.OTC_____ Milligrams/day _____

Medication _____ Milligrams/day _____ S.V.OTC_____ Milligrams/day _____

Medication _____ Milligrams/day _____ S.V.OTC_____ Milligrams/day _____

Medication _____ Milligrams/day _____ S.V.OTC_____ Milligrams/day _____

ALLERGIES - Please list all known allergies:

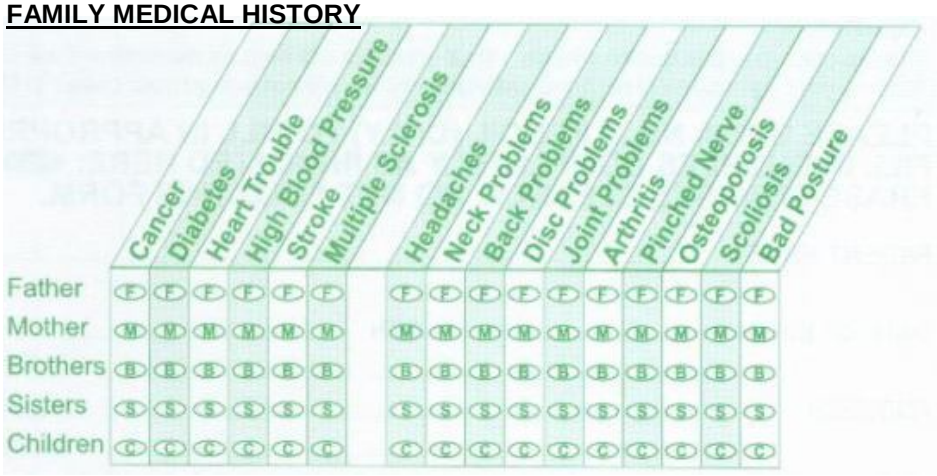
_____

_____

_____

_____

FAMILY MEDICAL HISTORY



SOCIAL HISTORY

Marital status: ❒ Single ❒Married ❒ Separated ❒Divorced ❒Widowed
Employment status: ❒ Employed ❒Homemaker ❒ Self Employed ❒Retired ❒Unemployed ❒Student
Domicile: ❒ Live alone ❒Live w/spouse ❒ With parents ❒ With children ❒ Assisted living
Use of alcohol: ❒ Never ❒ Occasionally ❒ Frequently ❒ Daily
Use of caffeine: ❒ Never ❒ Occasionally ❒ Frequently ❒ Daily
Use of tobacco: ❒ Never ❒ Previously, but quit_____ ❒ Current packs/day_____
Use of illicit drugs: ❒ Never ❒ Type/frequency_____