KRAFT
Chiropractic Clinic

ASYRA & MUSCLE TESTING PATIENT FORMS

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

Address: _____ City:_____

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

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

Home # _____ Cell #_____

Work # _____ Occupation:_____

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)

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

Informed Consent for Asyra Testing & Payment Information

I consent to having the ASYRA test and acknowledge that this test is intended to provide nutritional and homeopathic support. It is therefore not intended as a diagnosis, treatment, or cure of any disease. By signing this I understand that I am responsible for any payments due at the time services are rendered.

CANCELLATION POLICY: A 24-hour notice is required for cancellation of your ASYRA appointment. If a 24-hour notice is not provided, you will be charged a $35.00 fee.

All Asyra scans are $70.00.

_____ _____
Patient 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 time of my next appointment.

_____
Signature of Patient or Personal Representative Date

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

CONSENT TO EVALUATE 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 have ASYRA testing performed.

_____ _____
Print Name Date

_____
Signature

Patient Name:_____ **Date:**_____

Please check following conditions that you have or have had previously.

____ Allergies
____ Arthritis
____ Abdominal Pain
____ Blurred Vision
____ Poor Appetite
____ Hip Pain (Sacroiliac)
____ Cancer
____ Asthma
____ Bed Wetting
____ Depression
____ Diabetes
____ Constipation
____ Diarrhea
____ Gas/Gas Pains
____ Cramps
____ Dizziness
____ High Blood Pressure
____ Hemorrhoids
____ Epilepsy
____ Low Blood Pressure
____ Injury Back Pain
____ Fainting
____ Heart Pain
____ Low Back Pain
____ Headache
____ Heart Palpitations
____ Tailbone/Sacrum Pain
____ Hearing Trouble
____ Heart Attacks
____ Pins & Needles in Legs
____ Unable to Sleep
____ Liver Trouble
____ Gout
____ Bursitis
____ Anemia
____ Cold Feet
____ Run Down Feeling (Malaise)
____ Stomach Trouble
____ Ring or Buzzing in Ears
____ Ulcers
____ Swollen Ankles
____ Neck Pain
____ Painful Joints
____ Colitis
____ Pain in Forearm, Elbow
____ Swollen Joints
____ Appendicitis
____ Pain in Hand, Wrist
____ Pain Between Shoulders
____ Groin Pain
____ Pain in Head/ Face
____ Shortness of Breath
____ Menstrual Pain (PMS)
____ Menstrual Irregularity
____ Sinus
____ Gallbladder Troubles
____ Pain in Lower Leg, Knees
____ Thyroid Trouble
____ Kidney Trouble
____ Pain in Pelvic Region/Thigh
____ Pins & Needles in Hand/Arm
____ Indigestion
____ Cold Hands
____ Colds
____ Varicose Veins
____ Carpal Tunnel Syndrome
____ Difficulty Breathing
____ Bladder Problems
____ Cold Sweats
____ Bronchitis
____ Prostate Problems
____ Laryngitis
____ Pneumonia

What is your main issue/problem:_____

_____

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)

Describe any other symptoms related to this problem: _____

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:

_____

_____

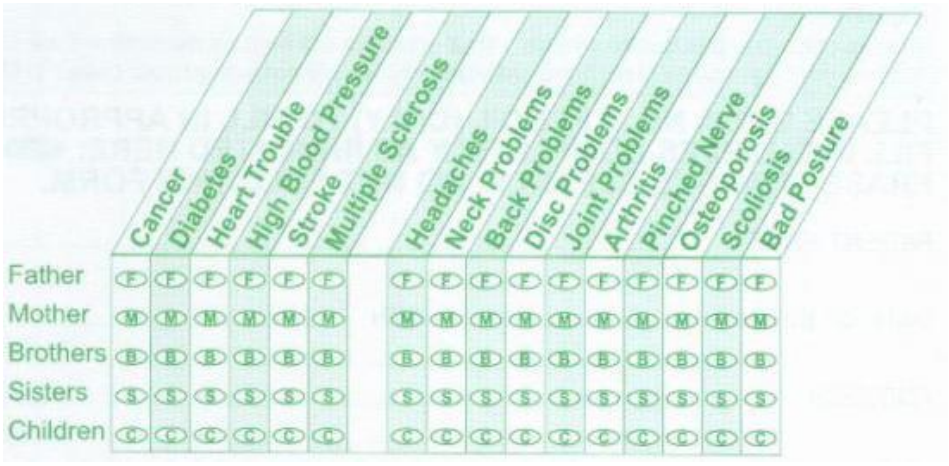
_____

_____

_____

_____

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 drugs: ❒ Never ❒ Type/frequency_____

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.

Patient Signature:_____ Date: _____/_____/_____