Adult/Child Form

Kinsella Chiropractic Clinic

407 South Sibley Avenue Litchfield, MN 55355
(320) 593-4494 Fax: (320) 593-4495

Patient First Name: ______________________________ M.I. _______ Last Name: __________________________________

Address: ____ City: ____________________ State: _____ Zip Code: __________

Birth date: _____________Age: ___Sex: M F Marital Status: M S W D Social Security #: _______________________

Home Phone: ____________________ Cell Number: ____________________ Email Address: _________________________

Employer: _______________________________ FT _____ PT _____ Employer Phone: _______________________________

Payment Choice: Medicare Minnesota Assistance Work Comp Auto Cash Insurance Name: ___________________

(Make sure we get a COPY of your Health Insurance Card!)

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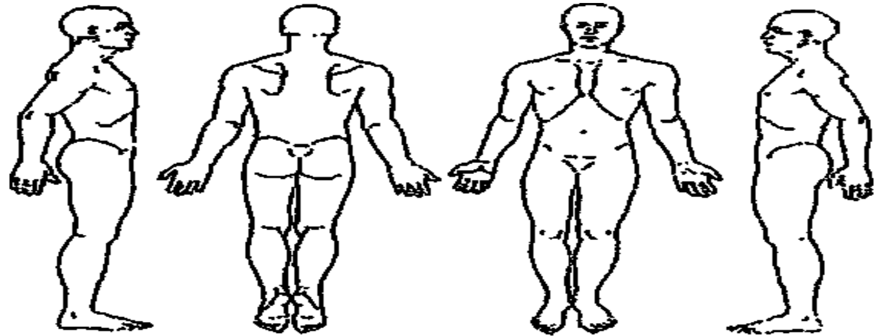
CHIEF COMPLAINT

Mark your area of discomfort with the described sensations. Use the appropriate symbols.

XXX	Burning (BU)
-----	Numbness (NU)
((((	Achy Pain (AC)
:::::	Sharp Pain (SH)
00	Pins & Needles



Symptoms began on (mm/dd/yyyy): ____/_____/________ How did symptoms start? ____________________________

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Average Pain Intensity?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

How often do you experience your symptoms?

(1) Constantly (76%-100% of the time) (2) frequently (51%-75% of the time) (3) Occasionally (26%-50% of the time) (4) Intermittently (0%-25% of the time)

How is your condition changing, since symptoms first started?

(1) N/A Symptoms recently started (2) Symptoms getting worse (3) Symptoms staying same (4) Symptoms improving (5) Symptoms on and off

What makes your condition better? ____

What makes your condition worse? ____

Does the pain interfere with your sleep? Y N Does the pain get worse at night? Y N

Does ice help? Y N Does heat help? Y N OTC medication? Y N If so, what brand? ________________________

Does your pain interfere with work or living? Y N If so, how? ____

In general, how would you rate your overall health? (1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

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QUESTIONS FOR HEADACHE

Do you experience: Nausea? Y N

Vomiting or Visual disturbance? Y N

Pain or cracking jaw? Y N

Abnormal Blood Pressure? Y N

QUESTIONS FOR NECK

Do you experience:

Difficulty turning your head? Y N

Pain or pressure behind eye? Y N

Numbness of hands/fingers? Y N

QUESTION FOR LOW BACK

Do you experience:

Numbness/tingling in feet? Y N

Pain down your legs? Y N

Change in bowel/bladder? Y N

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PAST MEDICAL HISTORY

Have you ever seen a chiropractor before? Y N For what condition? ____

Have you had this condition in the past? Y N If yes, when? ____

Have you seen a Medical doctor for your current complaint? Y N Doctor's Name: ____________________________

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Current Problems: Please **Circle all** Health Conditions that pertain to you.

General
Allergies
Depression
Dizziness
Fainting
Fever
Headaches
Loss of Sleep
Mental Illness
Nervousness
Tremors
Weight loss/gain

Muscle/Joint
Arthritis
Bursitis
Foot trouble
Muscle weakness
Low back pain
Neck pain
Mid back pain
Joint pain

Respiratory
Chest pain
Chronic cough
Difficulty breathing
Hay fever
Wheezing
Shortness of breath
Spitting up blood
Asthma

Eye, Ear, Nose & Throat
Colds
Deafness
Ear ache
Eye pain
Gum trouble
Hoarseness
Nasal obstruction
Nose bleeds
Ringing of the ears
Sinus infections
Tonsillitis
Vision problems

Genitourinary
Bed wetting
Bladder infection
Blood in urine
Kidney infection
Kidney stones
Prostrate trouble
Pus in urine
Stress incontinence
Painful urination
Decrease flow urination
Urgency to urinate

Gastrointestinal
Abdominal pain
Bloody or tarry stool
Colitis/ Crohns
Constipation
Diarrhea
Difficult digestion
Diverticulitis
Bloated abdomen
Excessive hunger
Gallbladder trouble
Hernia
Hemorrhoids
Intestinal worm
Jaundice
Liver trouble
Nausea
Painful defecation
Pain over stomach
Vomiting
Vomiting of blood

Cardiovascular
High blood pressure
Low blood pressure
Hardening of arteries
Irregular pulse
Pain over heart
Palpitation
Poor circulation
Rapid heart beat
Slow heart beat
Swelling in ankles

Women Only
Congested breast
Hot flashes
Lumps in breast
Menopause
Vaginal discharge
Are you pregnant?
Yes
No
If yes, how many months
________?

Habits	None	Light	Moderate	Heavy
Alcohol	O	O	O	O
Coffee	O	O	O	O
Tobacco	O	O	O	O
Exercise	O	O	O	O
Sleep	O	O	O	O
Soft drinks	O	O	O	O
Sugar	O	O	O	O

Any other condition **NOT** list, please provide here: ____
____

Please List **ALL** medications: ____
____

Please List **ALL** Vitamin Supplements: ____
____

Adult Illness (es): LIST all Health Conditions. **CIRCLE all CURRENT and PAST** conditions. **Write the DATE** immediately afterward.

ADD
Alzheimer
Anemia
Arthritis
Asthma
Cancer
Cerebral palsy
Chicken pox
Crohn's
CRPS (RSD)
CVA (stroke)
Cystic kidney disease
Depression
Diabetes
Eczema
Emphysema
Eye problems
Fibromyalgia
Heart disease
Hepatitis
HIV
Hypertension
Influenza pneumonia
Liver disease
Lung disease
Lupus erythema
Parkinson
Pleural effusion
Pneumonia
Multiple sclerosis
Psoriasis
Psychiatric problems
Scoliosis
Shingles
Vertigo
Thyroid problems

OTHER: ____

Doctor Signature: ________________________________ **Date:** ______________

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Childhood Illness (es): LIST all Health Conditions. **CIRCLE all CURRENT and PAST** conditions. **Write the DATE** immediately afterward.

ADD	Eczema	Allergies	Anemia	Asthma	Bedwetting
Cerebral palsy	Chicken pox	Depression	Diabetes	Ear infections	Drug exposure
Food allergies	Headaches	Hepatitis	HIV	Measles	Mumps
Psoriasis	Rash	Scoliosis	Seizure	Sickle cell anemia	Spina bifida

OTHER: ____

Surgery (ies): List ALL Surgical Procedures. **Write the DATE** of the Procedure immediately afterward.

Angioplasty	Appendectomy	Caesarian	Cardiac catheterization	Carpal tunnel
Coronary artery repair	Cosmetic	D & C	Dental surgery	Gall bladder
Hemorrhoidectomy	Hernia repair	Hysterectomy	Joint reconstruction	Joint replacement
Knee repair	Laminectomy	Mastectomy	Pacemaker insertion	Defibulator
Rotator cuff	Spinal fusion	Tonsillectomy	OTHER: ______________________	

Injury (ies): Mark or List ALL Injuries. **Write the DATE** of the Injury Immediately afterward.

Back injury	Broken bones	Disabilities	Fall (severe)	Fracture
Joint injury	Unconsciousness	Laceration	Motor vehicle	Soft tissue
Industrial accident	Head injury	OTHER: ______________________		

Family History (ies): If any blood relative has/had any of the following conditions, please circle and indicate which relative(s).

Alcoholism	Anemia	Cancer	Arthritis	Asthma	Bleed easily
Arteriosclerosis	Diabetes	Emphysema	Epilepsy	Glaucoma	Heart disease
High blood pressure	High cholesterol	Multiple sclerosis	Osteoporosis	Stroke	Thyroid disease

OTHER: ____

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______ **ACKNOWLEDGEMENT OF PRIVACY PRACTICES:** I have had the opportunity to obtain a copy of Notice of Privacy Practices for Protected Health Information (HIPAA). I have been informed that I may have a copy of this notice at any time. I have been informed that the Kinsella Chiropractic Clinic has available to me a copy of the Notice of Privacy Practice for Protected Health Information available at the front desk.

Patient Initials: ______

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______ **AUTHORIZATION TO RELEASE INFORMATION:** I hereby confirm that all the information provided by me is accurate. Any false information will result in my responsibility for any costs incurred due to fraudulent information. I authorize Kinsella Chiropractic Clinic to release any medical records necessary to process my insurance claim.

Patient Initials: ______

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______ **AUTHORIZATION OF PAYMENT:** I realize that any insurance that I have is a contract between me and that company. I authorize all insurance benefits to the Physician for services performed. I am responsible for providing the insurance information for the submission of claims. I authorize Kinsella Chiropractic Clinic to contact my insurance company for payments on my behalf. I am also responsible for any non-covered services or for services for which no referral was obtained. **Patient Initials:** ______

______ **DISCOUNT FOR PAYMENT AT TIME OF SERVICE AGREEMENT:** In light of my receiving a 30% discount for payment in full at the time of service, I hereby agree to the following:

1. I will not ask this clinic to file for services rendered to me under this arrangement from any insurance company, employer, welfare program, government entitlement program (Medicare or Medicaid), Workers compensation program or other third party payer.
2. This policy is only in effect if charges for professional services are paid in full on the day that they are rendered. This policy is only in effect for professionally services and does not apply to charges for nutritional supplements, orthotics, and support or other tangible goods.

Patient Initials: ______

Patient Signature: ____ **Date:** _______________

Doctor Signature: ____ **Date:** _______________