

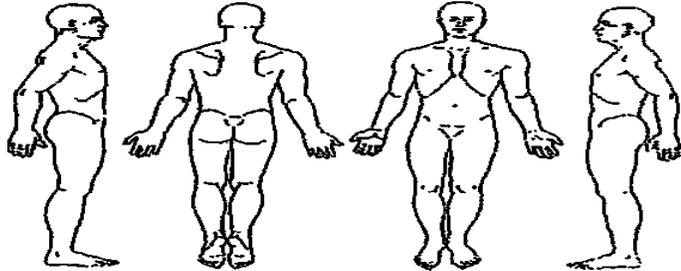


Patient First Name: _____ Middle: _____ Last Name: _____
 Mailing Address: _____ City/State: _____ Zip Code: _____
 Birth date: _____ Age: _____ Sex: M F Marital Status: M S W D Social Security #: _____
 Primary Phone: _____ Secondary Phone: _____
 Parent/Legal Guardian Name/Address/Phone: _____
 Email Address: _____
 Employer: _____ FT _____ PT _____ Employer Phone: _____
 Payment Choice: Medicare Minnesota Assistance Work Comp Auto Cash Insurance Name: _____
 What is your communication preference: Email Mail Phone Text
 Preferred Language: _____ Race: Asian African American Hispanic White Other: _____
 Tobacco Use: Current Smoker Non-Smoker Former Smoker

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? _____

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 yes, what brand? _____

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

How would you rate your overall health? 1 Excellent 2 Very good 3 Good 4 Fair 5 Poor

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

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: _____

Doctors Signature: _____ Date: _____



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

Adult & Child Form 2/3

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 problem

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/ Crohn's
- 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				
Coffee				
Sugar				
Exercise				
Sleep				
Soft drinks				

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

Please List **ALL** Medications, Dosage & Duration: _____

Please List **ALL** Drug Allergies: _____

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: _____

Doctors Signature: _____ Date: _____



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Adult & Child Form 3/3

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	Defibrillator
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: _____

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:** _____

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:** _____

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:** _____

CONSENT TO PHONE, TEXT AND EMAIL COMMUNICATION: By providing your signature below, you are providing consent to Kinsella Chiropractic Clinic to communication by phone, email and text messages regarding upcoming appointments and promotions. Your information will never be shared with any third party. You can opt-out at any time. **Patient Initials:** _____

DISCOUNT FOR PAYMENT AT TIME OF SERVICE AGREEMENT: In light of my receiving a 35% 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 to any insurance company, employer, welfare program, government entitlement program (Medicare or Medicaid) Worker 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 professional services & does not apply to charges for nutritional supplements, orthotics or other tangible goods.
- Patient Initials:** _____

**** Cash services and copays are due at the time of service. An APR of 5% with a minimum of \$5.00 will be added to your account if not paid in full after 60 days of service****

Patient Signature: _____ **Date:** _____

Parent/Guardian (please print & sign) _____ **Date:** _____

Doctor Signature: _____ **Date:** _____