



## *Patient Application Form*

WELCOME and THANK YOU for applying as a patient to our clinic. Our office specializes in research-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish an optimal rehabilitation program for you, and you are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

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***PATIENT NAME***

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***DATE COMPLETED***



## Patient Information

Name: \_\_\_\_\_ (Age) \_\_\_\_\_ Gender: M F

Home Address: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ Marital Status: S M D W

Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

How were you referred to this office? \_\_\_\_\_

## Experience with Chiropractic

Have you seen a Chiropractor before?  Yes  No How long were you treated? \_\_\_\_\_ When? \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for that visit(s): \_\_\_\_\_

How did you respond? \_\_\_\_\_

## Purpose For This Visit

What is your major complaint?: \_\_\_\_\_

Is this related to an accident or specific injury (other than auto or work related)\*?  Yes  No If yes, when: \_\_\_\_/\_\_\_\_/\_\_\_\_

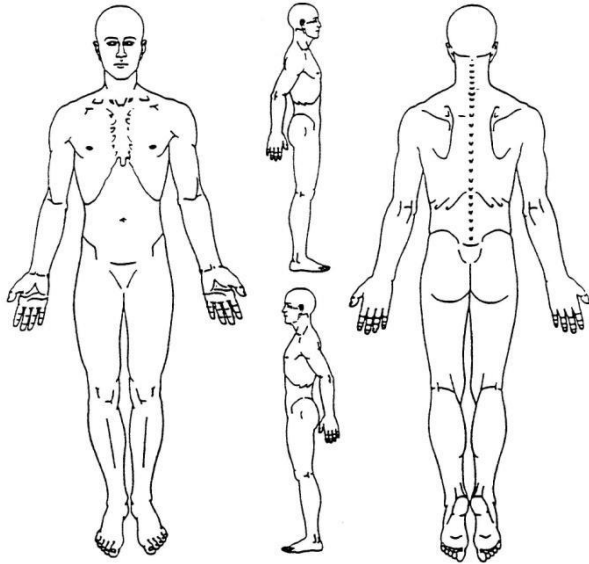
*\*If your symptoms are the result of an auto accident or work-related injury, please notify the front-desk person*

What caused your problem? \_\_\_\_\_

\_\_\_\_\_

## Show us your problem today

Write the letters below on the human figures to indicate the type and location of your symptoms



- 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 please use the additional boxes.

**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

How often are you experiencing it? (list your problem number next to your choice if more than one problem area)

- 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?

Bending    Looking down    Weight bearing

Coughing    Sitting

Lifting    Standing

Looking up    Walking

What have you done for this problem before coming in?

Bed Rest    Massage    Exercise    Dry Heat

Pain Meds    Wet Heat    Topical Ointment    Ice

Traction    Chiropractic    PT    MD    Nothing

Other: \_\_\_\_\_

What makes it better?

Adjustments    Hot baths    Pain meds

Bed rest    Ice    Resting

Exercising    Lying down    Traction

Dry heat    Massage    Nothing

Other: \_\_\_\_\_

Difficulties with Activities of Daily Living – Using a scale of 1 to 5, (1) you CAN do it to (5) you CAN'T do it because of PAIN, rating **only** your difficulties relating to your current problem.

Dressing\_\_\_\_ Walking\_\_\_\_ Sleeping\_\_\_\_ Self Hygiene\_\_\_\_

Driving\_\_\_\_ Daily Chores\_\_\_\_ Bending\_\_\_\_ Social Life\_\_\_\_

Lifting\_\_\_\_ Concentration\_\_\_\_ Standing\_\_\_\_ Exercising\_\_\_\_

Climbing Stairs\_\_\_\_ Sitting\_\_\_\_ Other\_\_\_\_\_

**Previous Illnesses & Major Injuries**

Year \_\_\_\_\_ Type \_\_\_\_\_ Residual problem \_\_\_\_\_

Year \_\_\_\_\_ Type \_\_\_\_\_ Residual problem \_\_\_\_\_

Year \_\_\_\_\_ Type \_\_\_\_\_ Residual problem \_\_\_\_\_

**Surgeries & Hospitalizations**

Year \_\_\_\_\_ Type \_\_\_\_\_ Residual problem \_\_\_\_\_

Year \_\_\_\_\_ Type \_\_\_\_\_ Residual problem \_\_\_\_\_

Year \_\_\_\_\_ Type \_\_\_\_\_ Residual problem \_\_\_\_\_

**Medications**

Medication \_\_\_\_\_ Milligrams/day \_\_\_\_\_

Medication \_\_\_\_\_ Milligrams/day \_\_\_\_\_

Medication \_\_\_\_\_ Milligrams/day \_\_\_\_\_

**Supplements**

Type \_\_\_\_\_ Milligrams/day \_\_\_\_\_

Type \_\_\_\_\_ Milligrams/day \_\_\_\_\_

Type \_\_\_\_\_ Milligrams/day \_\_\_\_\_

**Allergies** (please list)

\_\_\_\_\_



**Social History**

Marital Status:  Single  Married  Separated  Divorced  Widowed

Employment Status:  Employed  Homemaker  Retired  Unemployed  Student

Domicile:  Live alone  Live w/ spouse  Live w/ significant other  Live w/ parents  Live w/ children  Assisted living

Use of alcohol:  Never  Occasionally  Frequently  Daily

Use of caffeine:  Never  Occasionally  Frequently  Daily

Use of tobacco:  Never  Previously, but quit  Daily type/frequency \_\_\_\_\_

Use of drugs:  Never  Daily type/frequency \_\_\_\_\_

**Family Medical History**

**Place the corresponding letter below next to the disease/problem in the box**

- F** = Father
- M** = Mother
- B** = Brothers
- S** = Sisters
- C** = Children

Cancer _____	Diabetes _____
Heart trouble _____	High blood pressure _____
Stroke _____	Headaches _____
Neck problems _____	Back problems _____
Disc problems _____	Joint Problems _____
Arthritis _____	Pinched nerves _____
Osteoporosis _____	Scoliosis _____
Bad posture _____	Asthma _____
Stomach problems _____	Female trouble _____

**Pregnancy Release (female)**

This is to certify that to the best of my knowledge I am not pregnant and Dr. Kraft has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



## Terms of Acceptance / Informed Consent

I authorize and agree to allow the doctor and/or his designated staff to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal examination we encounter a non-chiropractic or unusual findings, we will advise the patient. If the patient requires specific diagnosis or treatment of those findings, we will recommend that they seek the services of another health care provider who specializes in that area. We do not promise to guarantee certain results or cure ailments. Additionally, as with any health care treatment, chiropractic treatment involves certain complications or risks. These may include, but are not limited to, the following: stiffness or soreness; muscle strain or spasms; aggravation or an increase of symptoms; disc injuries; dislocations; fractures; and stroke. Please also note that remaining untreated may also involve certain risks and may hinder the success of any future treatment.

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

I have read the above terms and informed consent. I intend for my signature below to cover terms and informed consent for my the entire course of my treatment. I wish to rely on the doctor to exercise his best judgment during the course of my treatment to accomplish what he feels to be in my best interests. **Do not sign until you have read and understand the above terms and informed consent.**

▶ Patient or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient or Guardian's Name Printed \_\_\_\_\_

## Assignment / Authorization

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits, we may require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment.

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill for any services that they are performing, these services are strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

**My signature indicates my understanding and agreement to the policies stated above.**

▶ Patient or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient or Guardian's Name Printed \_\_\_\_\_



**Acknowledgement of Receipt of Notice of Privacy Practices Pursuant to HIPPA and Consent for Use of Health Information**

I acknowledge that Kraft Chiropractic's Notice of Privacy Practices has been provided to me. I understand that I have a right to review Kraft Chiropractic'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. The Notice of Privacy Practices for Kraft Chiropractic is also provided on the request at the front desk of this practice and on Kraft Chiropractic's website at [www.kraftchiromi.com](http://www.kraftchiromi.com). The Notice of Privacy Practices also describes my rights and Kraft Chiropractic's duties with respect to my protected health information.

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



Patient/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient/Guardian's Name Printed \_\_\_\_\_

Description of Guardian's Authority \_\_\_\_\_

**Please give your insurance information/card to the front desk person to copy**