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.

____

PATIENT NAME

____

DATE COMPLETED

Patient Information

Name: ____ Height:_________ Weight:_________ Gender: M F

Home Address: ____ Home Phone: ( ) ________________________

City, State, Zip: ____ Work Phone: ( ) ________________________

Email Address: ____ Cell Phone: ( ) __________________________

Birth Date: ______ / ______/_________ Social Security #: ______________________________ Marital Status: S M D W

Occupation: ____ Employer Name: ____

Spouse's Name: ___________________________________ Cell Phone: ( )_________________________ #of Children: __________

Emergency Contact: ____ Phone: ( ) _____________________________

How were you referred to this office? ____

Experience with Chiropractic

Have you seen a Chiropractor before? ☐ Yes ☐ No Duration you were treated? ___________ When? _______/_______ /_______

Reason for previous visits: ____

How did you respond? ____

Purpose of 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? ____

____

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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 = tingling
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: ______________________________

When did it begin? __________________________

	mild								severe		
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: ______________________________

When did it begin? __________________________

	mild								severe		
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: ______________________________

When did it begin? __________________________

	mild								severe		
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: ______________________________

When did it begin? __________________________

	mild								severe		
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 # 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** **(All of the time)**

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What makes your problem worse?

☐Bending ☐Looking down ☐Coughing

☐Sitting ☐Lifting ☐Standing

☐Looking up ☐Walking

☐ Weight bearing

What have you done for this problem before coming in?

☐Bed Rest ☐Massage ☐Exercise ☐Wet Heat

☐Dry Heat ☐Pain Meds ☐Topical Ointment

☐Ice ☐Traction ☐Chiropractic ☐PT ☐MD

☐Nothing ☐Other: ______________________

What makes your problem better?

☐Adjustments ☐Wet Heat ☐Ice

☐Pain meds ☐Bed rest ☐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 the difficulties you have 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 Serious Illness (Cancer, Diabetes, Heart, etc.)

Year __________ Type____________________________________ Residual problem _____________________________

Year __________ Type____________________________________ Residual problem _____________________________

Major Injuries (Broken Bone, Auto Accident, Fall, etc.)

Year __________ Type____________________________________ Residual problem _____________________________

Year __________ Type____________________________________ Residual problem _____________________________

Surgeries & Hospitalizations

Year __________ Type____________________________________ Residual problem _____________________________

Year __________ Type____________________________________ Residual problem _____________________________

Medications

Medication ______________________ Milligrams/day _______

Medication ______________________ Milligrams/day _______

Medication ______________________ Milligrams/day _______

Vitamins & Supplements

Type ______________________Milligrams/day________

Type ______________________ Milligrams/day________

Type ______________________ Milligrams/day________

Allergies (please list)

____

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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.

M = Mother
F = Father
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 possibly 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. 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