Kraft Chiropractic

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

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Patient Information

Name: _____ Height:_____ Weight:_____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: _____ / _____/_____ 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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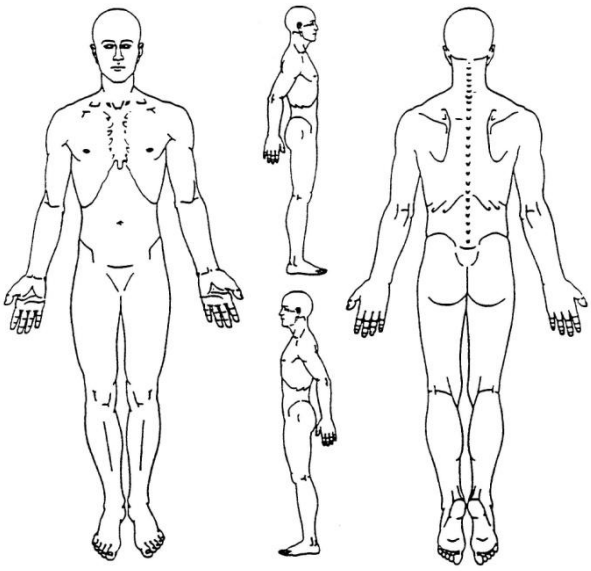
Show us your problem today

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**	☐ **Occasionally**	☐ **Intermittently**	☐ **Frequently**	☐ **Constantly**
(Less than daily)	**(1/4 of the time)**	**(1/2 of the time)**	**(3/4 of the time)**	**(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 _____ /_____ /_____

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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

Kraft Chiropractic
3330 Rochester Rd.
Troy, MI 48083
(248) 740-9100

What to expect after the first visit

Please read the following information carefully. Sign the bottom of the sheet to indicate that you understand the instructions and information given.

1. If you have never been adjusted, or if it has been some time since your last adjustment, you may experience soreness or discomfort for a few hours to a few days as your muscle acclimate to the proper spinal position.
2. If you are sore, Dr. Kraft may recommend either ice or moist heat application to help with your healing. When recommended, ice or moist heat (i.e. shower, bath, moist heating pad) should be used for no more that 15 minutes per hour. Do not apply ice directly to bare skin, always protect your skin with a thin covering such as a shirt or towel.
3. Do not use dry heat or analgesic rubs (i.e Icy Hot, BenGay, etc.) for your spinal condition as it will cause further swelling and increased discomfort.
4. Avoid heavy lifting or repetitive movements until Dr. Kraft indicates that you are ready for normal activity.
5. Unless indicated by Dr. Kraft, you may return to work/school after your appointment. It is best to rest after an adjustment to help retain its position.
6. Healing takes time. Please be patient with your progress as most spinal problems have degenerated to the point of symptoms over many years. Dr. Kraft appreciates your communication.
7. Appointment scheduling is appreciated to track your care plan, your progress, and to deliver the highest quality of care for you.
8. If a sudden movement causes discomfort, or if you experience any relapse of your problem, please contact Kraft Chiropractic at (248) 740-9100. The office number is covered after hours as well.

I have read and understand the instructions given for my follow up care.

_____ _____

Patient Signature Date

Kraft Chiropractic
3330 Rochester Rd.
Troy, MI 48083
(248) 740-9100

COMMUNICATION STATEMENT

As a convenience to our patients, Kraft Chiropractic offers three options for appointment reminders. Please choose one option. (All options are a 24 hour notice unless you request otherwise).

Email:

E-mail _____

OR

Phone Call:

Please leave a phone message at _____

OR

Text Message:

A text message at _____

Circle your phone provider:
(Notice – your phone company may charge you extra if you do not have a texting plan)

Verizon AT&T Sprint T Mobile Virgin Mobile Other:_____

_____

Patient/ Representative Signature Date