Kraken Chiropractic
New Patient Intake Form

Name_____ Date_____

Date of Birth_____ Age_____ Sex _____ Referred By_____

Address_____City_____ State_____Zip_____

Phone_____ E-Mail_____

Occupation_____ Employer_____

Have you ever received Chiropractic Care? Yes No If yes, when?_____

Primary Care Physician _____ Location _____

Will you be using insurance for your visit? Yes No Insurance carrier if yes _____

Chief Complaint: _____

When did the Complaint Begin ? _____

Describe how the complaint started: _____

Please circle the Quality of the complaint/pain: *dull aching sharp shooting burning throbbing deep other* _____

Does this complaint/pain radiate, or travel, to any other areas of your body? _____

Do you have any numbness or tingling? If so, Where? _____

How frequent is the complaint present & how long does it last? _____

Does anything aggravate the complaint?_____

Does anything make the complaint feel better? _____

Grade the Severity of Pain (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain imaginable)

Previous interventions

List treatments, surgeries, or other care you have sought for your complaint: _____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge. Yes No

I hereby authorize the office of Kraken Chiropractic to provide me with chiropractic care in accordance with this state's statutes.

Patient Signature _____ Date _____

Doctors Signature _____ Date_____

REVIEW OF SYSTEMS

Check (✓) the following conditions that apply to your health.

Check here if none apply ➡ ☐

Place Patient Sticker Here

Revised 10/7/14

1. CONSTITUTIONAL
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Weight gain
- ☐ Weight loss

2. HEENT
- ☐ Hearing loss
- ☐ Sinus pressure
- ☐ Visual changes

3. RESPIRATORY
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

4. CARDIOVASCULAR
- ☐ Chest pain
- ☐ Pain while walking (Claudication)
- ☐ Edema
- ☐ Palpitations

5. GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting

6. GENITOURINARY
- ☐ Painful urination (Dysuria)
- ☐ Excessive amount of urine (Polyuria)
- ☐ Urinary frequency

7. METABOLIC/ENDOCRINE
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst (Polydipsia)
- ☐ Excessive hunger (Polyphagia)

8. NEUROLOGICAL
- ☐ Dizziness
- ☐ Extremity numbness
- ☐ Extremity weakness
- ☐ Headaches
- ☐ Seizures
- ☐ Tremors

9. PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression

10. INTEGUMENTARY
- ☐ Breast discharge
- ☐ Breast lump
- ☐ Hives
- ☐ Mole change(s)
- ☐ Rash
- ☐ Skin lesion

11. MUSCULOSKELETAL
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Neck pain

12. HEMATOLOGIC
- ☐ Easily bleeds
- ☐ Easily bruises
- ☐ Lymphedema
- ☐ Issues with blood clots

13. IMMUNOLOGIC
- ☐ Food allergies
- ☐ Seasonal allergies

Kraken Chiropractic

Patient Privacy Form

I understand that as part of my health care, Dr. Perry Grunewald (**Physician**) originates and maintains health records describing my health history, symptoms, examinations, test results, diagnosis', treatments, and plans for future care. I understand that this information is utilized to plan my care and treatments, to bill for services provided to me, to communicate with other healthcare providers, and other routine healthcare functions such as assessing quality and reviewing competence of healthcare professionals.

The **Physician's** *Notice of Privacy Practice* provides specific information and a complete description of how personal health information may be used and disclosed. I have been provided with a copy of or access to the *Notice of Privacy Practice* and understand that I have the right to review the notice prior to signing this consent. I understand that the **Physician** reserves the right to change the Practices. *Notice of Privacy Practice* prior to implementation of the revised *Notice of Privacy*, the revised Notice will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment, or healthcare functions and that the **Physician** is not required to agree to the restrictions requested. I may revoke the consent at any time in writing except to the extent that the Physician has already acted in reliance on my prior consent. This consent is valid until revoked by me in writing.

I REQUEST THE FOLLOWING RESTRICTIONS ON THE USE OF AND/OR DISCLOSURE OF MY PERSONAL HEALTH INFORMATION._____

I further request that any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my written authorization except as otherwise provided by law. I have been provided with and have reviewed the **Physician's** *Notice of Privacy Practices.*

Signature of Patient or Legal Representative Date

Kraken Chiropractic

Consent To Treat

I hereby request and consent to the performance of chiropractic adjustments and other therapy procedures to be performed on myself or (minor) _____ by Dr. Perry Grunewald. I also consent to the procedures performed by his trained staff under direction and supervision.

I have had an opportunity to discuss with the doctor or other office staff, the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of chiropractic nor medicine is not an exact science and that my care may involve the making of judgements based upon the facts known by the doctor at that time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgement; that no guarantee to results has been made to, nor relied upon by me, and I wish to rely on the doctor to exercise judgement during the course of the procedures which he feels at the time, based upon the facts then unknown is in my best interest.

I have also been advised that although the incident of complications associated with chiropractic procedures is very low, anyone undergoing chiropractic adjustments, physical therapy, or joint manipulation procedures should know of possible complications, which have been alleged. These include, but are not limited to; burns, fractures, disc injuries, strokes, dislocations, sprains, increase or worsening of symptoms, and those which relate to aberrations unknown or reasonably undetectable by the doctor.

I have read or have had the above consent read to me. I have also had the opportunity to ask questions about its contents, and by signing below, acknowledge my understanding of its contents.

Patient Name (Print): _____

Patient Signature: _____Date:_____

Relationship or Authority if not signed by the patient: _____

Patient counseled by: Discussion ____ Other (specify)_____

Doctor's signature:_____