

General Information

Name: _____ Age: _____ Today's Date: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____
 Birth Date: _____
 Occupation: _____ Employer: _____
 E-Mail: _____ Spouse's Employer: _____
 Marital Status: Married Single Divorced Separated Widowed
 Name of spouse: _____ Number of Children: _____
 Person to contact in an emergency: _____ Phone # _____

Whom can we thank for referring you to us? _____
 If not a referral- how else did you hear about us: _____

Insurance Information

Name of person responsible for this account? _____
 Relationship to patient _____ Phone # _____

Type of insurance: Health insurance Worker's Comp. Automobile Insurance

Primary Insurance Company: _____ Name of insured: _____
 Relationship to insured: _____ Policy Holders Date of Birth _____

Secondary Insurance Company: _____ Name of insured: _____
 Relationship to insured: _____ Policy Holders Date of Birth _____

General History

Sex: Male Female Height: _____ ft. _____ in. Weight _____ lbs.
 What type of exercise do you perform on a daily basis? None Light Moderate Heavy
 Do you smoke? No Yes If yes, how much? _____ pack(s) per day
 Is there any chance of you being pregnant? Yes No
 Have you previously been under chiropractic care? Yes No
 List any broken bones and/ or surgeries: _____

Check any of the following you may have:

- | | | | |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Gas | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Colitis | <input type="checkbox"/> Gall bladder | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Lower back pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Male Problems |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> High blood pres. | <input type="checkbox"/> Female problems |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Low Blood pres. | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Heart Disorders | <input type="checkbox"/> Leg pains |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> H.I.V. |

Current Condition Information

Describe Your Major Complaint: _____

Describe any accidents, falls, etc. that may have caused your problem: _____

How long have you had this problem? _____

Is your problem a result of a: Work accident? Yes No Auto Accident? Yes No

Have you had similar symptoms or injuries before? Yes No If Yes, please explain: _____

What other doctors have you seen for this condition: _____

What tests have you had for this problem and when were they performed? _____

Check any previous treatments: None, Chiropractic, Pain Medications, Rest, Heat, Ice,
 Muscle Relaxers, Physical Therapy, Injections, Surgery, Exercise

Results of previous Treatment: _____

Is there anything you've done that makes your condition worse? _____

Does this problem interfere with your normal living and/ or work? Check all activities that are affected:

A. **Home** : Bathing, Showering, Sitting, Dressing, Standing, Making Bed,
 Putting on Shoes, Doing Laundry, Grasping Things, Other: _____

B. **Physical Activities**: Bending, Lifting, Twisting, Computer Use, Leaning,
 Walking, Kneeling, Climbing Stairs, Pushing Things, Pulling Things,
 Other: _____

C. **Recreational Life**: Exercising, Sports, Hobbies, Dining Out, Driving,
 Other: _____

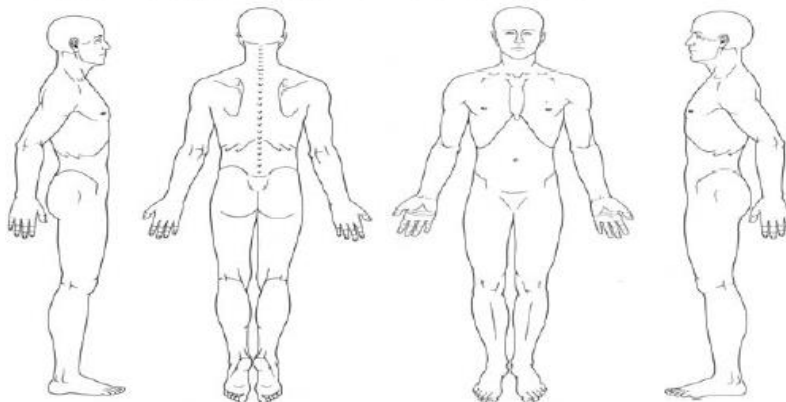
D. **Rest**: Sleep, Other: _____

E. Have you missed any work days? Yes No Dates missed: _____

How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



What describes the nature of your symptoms?

- Sharp Shooting
- Dull Ache Burning
- Numb Tingling

Has this problem been:

- Getting better
- Getting worse
- Staying the same

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ Unbearable

Circle Level of Pain or Intensity (Above)

Past Traumas

1. Year: _____ Description: _____

2. Year: _____ Description: _____

3. Year: _____ Description: _____

Authorization, Assignment, and Release

Waiting for insurance payment is a courtesy provided by our office. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits in order to lessen the initial financial burden for you while waiting for reimbursement. The insurance carriers are billed on a weekly cycle.

I hereby instruct and direct my insurance company to pay by check, made out and mailed directly to this clinic. The professional and medical expense benefits allowable and otherwise payable to me under my current insurance policy will be used as a payment toward the total charge for professional services rendered by this clinic.

I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster and/or attorney involved in this case; and hereby release this clinic of any consequence thereof.

Acknowledgement and Understanding

I acknowledge and agree to the following:

The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Chiropractic is not a treatment for any condition or symptom. It is a care system that is aimed toward the reduction and correction of spinal subluxations so that your body as a whole may function better.

Although chiropractic care is one of the safest forms of health care, it is associated with some minor risks, and it is my responsibility to be informed about those risks by asking the doctor or a staff member prior to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

I clearly understand that my records and x-rays are property of Kamego Chiropractic Clinic and that in case I need a copy of my records and x-rays, there will be an additional charge for that.

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Kamego Chiropractic Clinic's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Kamego Chiropractic Clinic's Notice of Privacy Practices prior to signing this document. Kamego Chiropractic Clinic's Notice of Privacy Practices has been provided to me. 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 Kamego Chiropractic Clinic. The Notice of Privacy Practices for Kamego Chiropractic Clinic is also provided on request at the main administrative desk of this practice and on Kamego Chiropractic Clinic's website at www.kamego.topchiro.com. This Notice of Privacy Practices also describes my rights and Kamego Chiropractic Clinic's duties with respect to my protected health information.

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

Financial Responsibility & Consent for Treatment

I understand and agree that (Regardless of insurance status); I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on all sides of this packet and have completed all questions. I certify this information is true and correct to the best of my knowledge. I will not hold my doctor or any staff member of Kamego Chiropractic Clinic responsible for any errors or omissions that I may have made in the completion of this form. I will notify the Chiropractic Clinic of any changes in my health status or above information.

Fees are payable at the time of service, unless other arrangements have been made in advance. I hereby give permission for treatment.

Patient's Signature: _____ Date: _____

Parent/ Legal Guardian (If Minor): _____ Date: _____

Coordinated Care Communications

Dr. Kamego feels that it is very important that we coordinate with your doctors and keep them up to date on your treatment and progress here at our office. Please fill in any and all information, by doing so I give authorization to Kamego Chiropractic Clinic to release my health care information to the offices and / or providers below.

General Physician:
Address:
City, State, Zip:
Phone Number:

Podiatrist:
Address:
City, State, Zip:
Phone Number:

OB/GYN:
Address:
City, State, Zip:
Phone Number:

Other:
Address:
City, State, Zip:
Phone Number: