KINSI
CHIROPRACTIC • SPORTS MEDICINE • RECOVERY

Patient Information

Last Name: _____First Name: _____MI:___

Address: _____ Apt No.: _____ City: _____

State:_____ Zip:_____

Home Phone: _____ Cell Phone:_____

Email: _____

Date of Birth: _____/_____/_____

Employer/Name of School_____ ☐ Full Time ☐ Part Time

Sex: ☐ Male ☐ Female Martial Status: ☐ married ☐ single ☐ divorced ☐ widowed

Patient Referral Information:

Referred By:_____ How did your hear about us?:_____

Have you been to Chiropractor before: ☐ Yes ☐ No

If Yes, who did you go see and when was last time you have been adjusted?:_____

Emergency Contact:

Name:_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip:_____

HomePhone: _____ Cell Phone:_____

Patient's Present Complaints

Patient Name:_____

Present Complaints:

_____

Who is your primary care physician (PCP)?_____

Please list your symptoms in order severity:_____

_____

How did your problem begin:_____

Patient Initial

Date problem began:_____/_____/_____

What treatments have you undergone for this condition in the past? (surgery, medications, injections, therapy, chiropractic)_____

Have you had X-rays, MRIS or other tests for this condition? ☐ Yes ☐ No

If yes, what tests and when?: _____

Is this condition the result of an auto or work accident? ☐ Yes ☐ No

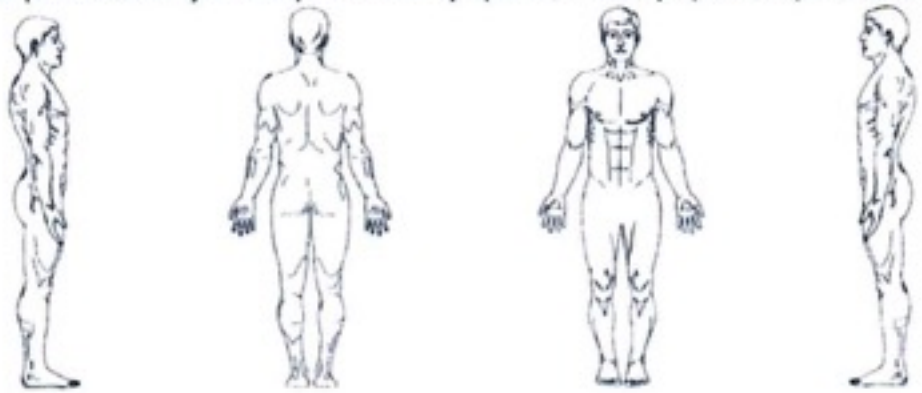
If yes, please explain:_____

How bad is your pain? (circle a number) 0 1 2 3 4 5 6 7 8 9 10

No pain — Unbearable Pain

How often are your symptoms present?	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Intermittently
Describe your current pain/symptoms:	☐ Sharp/Stabbing ☐ Dull ☐ Numbness ☐ Burning	☐ Throbbing ☐ Soreness ☐ Shooting ☐ Tingling	☐ Aches ☐ Weakness ☐ Gripping ☐ Other _____	
Since it began, is your problem:	☐ Improving	☐ Getting Worse	☐ No Change	
What makes the problem better?	☐ Nothing ☐ Standing ☐ Exercise	☐ Lying Down ☐ Sitting ☐ Inactivity/Rest	☐ Walking ☐ Movement ☐ Other _____	
What makes the problem worse?	☐ Nothing ☐ Standing ☐ Exercise	☐ Lying Down ☐ Sitting ☐ Inactivity/Rest	☐ Walking ☐ Movement ☐ Other _____	
Can you perform your daily home activities?	☐ Yes	☐ Yes, only with help	☐ Not at all	
Do you exercise?	☐ Yes, almost daily	☐ Yes, occasionally	☐ Not at all	
Describe your job requirements:	☐ Mainly sitting	☐ Light labor	☐ Heavy labor	
Does your job include working with computers?		☐ Yes	☐ No	
Can you perform your daily work activities?	☐ Yes, all activities	☐ Only some	☐ Not at all	
Describe your stress level:	☐ None to mild	☐ Moderate	☐ High	

Mark an X on the pictures where you have pain or other symptoms; include symptoms of pain, numbness or tingling.



Patient Initial

Patient Medical History

Patient Name: _____

Females only:

Are/or could you be pregnant?
☐ No ☐ Yes
Due Date: _____

Are you nursing?
☐ No ☐ Yes

Do you have breast implants?
☐ No ☐ Yes

Surgeries:

☐ No Surgeries
☐ Cardiovascular Procedure
☐ Joint Replacement
☐ Prostate Surgery
☐ Appendectomy
☐ Cervical Disc Procedure
☐ Laminectomies
☐ Other _____
☐ Broken Bone
☐ Gastric Bypass
☐ Lumbar Disc Procedure
☐ Cancer Treatment
☐ Hysterectomy
☐ Mastectomy

Medical Conditions:

☐ No Medical Conditions
☐ Heart Disease
☐ Stroke
☐ Arthritis
☐ Hepatitis B
☐ Other _____
☐ Cancer
☐ Hypertension
☐ Diabetes
☐ Skin Disorder

Allergies:

☐ No Known Allergies
☐ Medications
☐ Soy
☐ Eggs
☐ Milk Or Lactose
☐ Sulfites
☐ Fish And Shellfish
☐ Peanut
☐ Wheat/Gluten
☐ Latex Or Adhesives
☐ Penicillin
☐ Other _____

Social History:

☐ Caffeine Used Occasionally
☐ Drink Alcohol Often
☐ Experience Stress Ocasionally
☐ Wear Seatbelts Always
☐ Caffeine Used Often
☐ Exercise Not At All
☐ Experience Stress Often
☐ Wear Seatbelts Never
☐ Chew Tobacco
☐ Exercise Occasionally
☐ Smoke 1 Pack or Less Per Day
☐ Wear Seatbelts Usually
☐ Drink Alcohol Occasionally
☐ Exercise Often
☐ Smoke More Than 1 Pack Per Day

Family History:

☐ No Family History
☐ Cholesterol
☐ Heart Problems
☐ Stroke
☐ Autoimmune Disease
☐ Chronic Back Pain
☐ High Blood Pressure
☐ Thyroid
☐ Arthritis
☐ Chronic Headaches
☐ Osteoporosis
☐ Who _____
☐ Cancer
☐ Diabetes
☐ Psychiatric

Occupational Activities:

☐ Administration
☐ Daycare/Childcare
☐ Food Service Industry
☐ Household
☐ Military
☐ Retail Worker
☐ Technology
☐ Business Owner
☐ Electrical/ Secretarial
☐ Healthcare
☐ Legal
☐ Pilot
☐ Retired
☐ Truck Driver
☐ Construction
☐ Executive/Legal
☐ Heavy Equipment Operator
☐ Manual Labor
☐ Police/Fire
☐ Student
☐ Other_____
☐ Computer User
☐ Flight Attendant
☐ Home Service
☐ Manufacturing
☐ Professional Athlete
☐ Teacher

Recreational Activities:

☐ Backpacking
☐ Dance
☐ Martial Arts
☐ Soccer
☐ Weight Lifting
☐ Basketball
☐ Football
☐ Racket Ball
☐ Swimming
☐ Other _____
☐ Biking
☐ Golf
☐ Running
☐ Tennis
☐ Boating/Crew
☐ Horse Back Riding
☐ Skiing
☐ Walking

Exercise Classes:

☐ Zumba ☐ Cross Fit ☐ Yoga ☐ Pilates/Barre ☐ Spin
☐ Other _____

Please list any medications/supplements that you are currently taking:_____

_____

Patient Initial

Review of Systems

Patient Name:_____

Cardiovascular:

	Present	Past	No
Aortic Aneurism	☐	☐	☐
Cardiac Catheter	☐	☐	☐
Chest Pain	☐	☐	☐
Poor Circulation	☐	☐	☐
Heart Attack	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Heart Disease	☐	☐	☐
Irregular Heartbeat	☐	☐	☐
Jaw Pain	☐	☐	☐
Pace Maker	☐	☐	☐
Swelling or Legs	☐	☐	☐
Vascular Disease	☐	☐	☐

Genitourinary:

	Present	Past	No
Blood in Urine	☐	☐	☐
Burning Urination	☐	☐	☐
Frequent Urination	☐	☐	☐
Kidney Disease	☐	☐	☐
Kidney Stone	☐	☐	☐
Lower Side Pain	☐	☐	☐

Hematologic/Lymphatic

	Present	Past	No
Blood Clots	☐	☐	☐
Cancer	☐	☐	☐
Easy Bruising	☐	☐	☐
Easy Bleeding	☐	☐	☐
Fevers/Chills/Sweats	☐	☐	☐
Hepatitis	☐	☐	☐

Respiratory:

	Present	Past	No
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Cold/Flu	☐	☐	☐
Cough/Wheezing	☐	☐	☐
Emphysema	☐	☐	☐
Pneumonia	☐	☐	☐
Shortness of Breath	☐	☐	☐
Tuberculosis	☐	☐	☐

Present Height:_____

Present Weight:_____

Ears/Nose/Throat:

	Present	Past	No
Bleeding Gums	☐	☐	☐
Difficulty Swallowing	☐	☐	☐
Dizziness/Vertigo	☐	☐	☐
Hearing Loss	☐	☐	☐
Nosebleed	☐	☐	☐
Ringing in Ears	☐	☐	☐
Sinus Infection	☐	☐	☐
Sore Throat	☐	☐	☐
Swollen Glands	☐	☐	☐

Eyes:

	Present	Past	No
Blurred Vision	☐	☐	☐
Cataracts	☐	☐	☐
Double Vision	☐	☐	☐
Glaucoma	☐	☐	☐
Loss of Vision	☐	☐	☐

Integumentary:

	Present	Past	No
Eczema	☐	☐	☐
Cancer	☐	☐	☐
Psoriasis	☐	☐	☐
Rashes	☐	☐	☐
Skin Disease	☐	☐	☐
Skin Lesions	☐	☐	☐
Skin Ulcers	☐	☐	☐

Allergic/Immunologic:

	Present	Past	No
Allergy Shots	☐	☐	☐
Cortisone Use	☐	☐	☐
Hives	☐	☐	☐
HIV/AIDS	☐	☐	☐
Immune Disorder	☐	☐	☐

Gastrointestinal:

	Present	Past	No
Abdominal Pain	☐	☐	☐
Bloody Stools	☐	☐	☐
Bowel Problems	☐	☐	☐
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Gallbladder Problems	☐	☐	☐
Liver Problems	☐	☐	☐
Nausea/Vomiting	☐	☐	☐
Poor Appetite	☐	☐	☐
Ulcers	☐	☐	☐

Musculoskeletal:

	Present	Past	No
Arthritis	☐	☐	☐
Broken Bones	☐	☐	☐
Gout	☐	☐	☐
Joints Stiffness	☐	☐	☐
Osteoporosis	☐	☐	☐
Tendinitis	☐	☐	☐

Endocrine:

	Present	Past	No
Diabetes	☐	☐	☐
Hair Loss	☐	☐	☐
Menopausal	☐	☐	☐
Menstrual Problems	☐	☐	☐
Thyroid Disease	☐	☐	☐

Psychiatric:

	Present	Past	No
Anxiety Disorder	☐	☐	☐
Depression	☐	☐	☐
Unusual Stress	☐	☐	☐

Constitutional:

	Present	Past	No
Change In Activity	☐	☐	☐
Difficulty Sleeping	☐	☐	☐
Energy Level Problem	☐	☐	☐
Weight Loss/Gain	☐	☐	☐

Neurological:

	Present	Past	No
Babinski	☐	☐	☐
Brain Aneurysm	☐	☐	☐
Carpal Tunnel	☐	☐	☐
Head Injury	☐	☐	☐
Meningitis	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Numbness	☐	☐	☐
Parkinson's Disease	☐	☐	☐
Pinched Nerves	☐	☐	☐
Seizures	☐	☐	☐
Severe Headaches	☐	☐	☐
Loss of Balance	☐	☐	☐
Stroke	☐	☐	☐

Patient Initial

Dr Cody Marlow Dr Hannah Goforth

211 Welsh Pool Road Suite 106
Exton, Pa 19341

I hereby volunteer to receiving the following treatments for my present and future health conditions. I understand the treatment will be administered by Kinisi LLC.

Treatments that may be administered.

Electrical Stimulation: is a treatment that involves the use of electric devices such as TENS (Transcutaneous Electrical Nerve), or MENS (Micro current Electrical Nerve) units. Mild electrical impulses are transmitted through the skin to stimulate nerve fibers. Contraindications are, Pacemaker, Pregnancy, Epilepsy/Seizures (no treatment above the neck) Cancer. The electrodes are on self adhesive pads that have a gel and there is the rare possibility that your skin may be agitated.

Cupping: is a treatment of creating a vacuum in a glass or plastic cup, which is applied to the surface of the skin. After the cups are removed there may be a slight discoloration of the skin (like a type of bruising) this usually will resolve in a 3-7 days.

Taping: Our taping treatments usually consist of utilizing kinesiotape (RockTape), in order to provide relief to an area of injury. There can be irritation to the area applied if one is allergic to the glue used on the tape and the tape should be removed immediately and the area washed if this happens.

IASTM: is scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising at the treatment area, it is not usually painful and resolves in 3-7 days.

Therapeutic Ultrasound: is a treatment that is used to provide deep heating and healing to soft tissues in the body. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns does exist.

Myofascial Release: is a safe and very effective hands-on technique that involves applying sustained pressure into the myofascial connective tissue restrictions to eliminate pain and restore motion. This can often result in bruising at the treatment area, it is not usually painful and resolves in 3-7 days.

I understand that no promise has been made regarding the outcome of treatment and that reasonable efforts will be made to give information to me so that I might make an educated decision regarding the duration and appropriateness of continued care. I do not expect the doctor to be able to anticipate and explain all the risks and complications. I wish to rely on the doctor to exercise judgement during treatment, which he/she feels at the time, based upon the facts then known, and is in my best interest.

By signing below, I acknowledge that:

I have read or have had read to me the information on this consent form. I understand the possible risks and complications involved. I have had the opportunity to discuss the consent with the doctor. I understand I can request more information at any time if desired. I consent to receiving treatment that involves the above procedures. I understand that I have the rights to refuse or discontinue any treatment at any time. I understand that this refusal may affect the expected results.

Patient Name (PRINTED)_____

Patient/Guardian Signature_____

Date_____

Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first few days of treatment.
2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

Patient Name (PRINTED)_____

Patient/Guardian Signature_____

Date_____