Deep Wellness CHIROPRACTIC

Patient Name: _____

Aloha and **welcome** to our practice. We are honored that you chose to trust us with your health care. Healing is a partnership between patient and provider, and it begins with these forms. **Please help us to help you** by *printing out these forms and setting aside about forty-five minutes to complete them in detail*. Bring the completed forms with you on your first visit. If you do not have access to a printer, please arrive for your first-time appointment about 45 minutes early to complete the forms in our office.

Mahalo,
Dr. Frederick Kennedy, Chiropractor

Title: **Mr. Mrs. Ms. Dr.** Full Legal Name:

Preferred Name: Sex: **M F** Status: **M S D W** Birth Date: Age:

Postal Address: City: State: Zip:

Cell #: Home/Work #: Email:

Occupation: Employer:

Emergency Contact: Emergency Phone:

Referred By: **DC MD DO Sign Newspaper Facebook Mailing Internet Patient/Friend?:**

Ever received Chiropractic Care: **NO YES When?** Doc's Name:

"I, the undersigned, grant permission for Dr. Frederick Kennedy, Chiropractor, to perform chiropractic exams, adjustments, and/or myofascial trigger point therapy in accordance with his findings and recommendations. I understand that Dr. Kennedy does not diagnose or treat any specific condition and that all services are rendered for the purpose of improved function. I agree to pay in full for all services rendered at the time of service."

Patient or Guardian Signature: _____ Today's Date: _____

Deep Wellness Chiropractic / Dr. Frederick Kennedy, Chiropractor
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doc@afkennedy.com www.deepwellnesschiropractic.com

Deep Wellness CHIROPRACTIC

Patient Name: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to chiropractic school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Patient or Guardian Signature: _____ **Today's Date:** _____

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Patient Name: _____

PAST HEALTH HISTORY

Surgeries: Date Type of Surgery

_____ _____

_____ _____

_____ _____

Previous Injury or Trauma: _____

Have you ever broken any bones? Which? _____

Allergies: _____

Family Health History: Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Heart disease □ Neurological diseases

□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease

□ Diabetes □ Other _____ □ None of the above

Deaths in immediate family: Cause of parents' or siblings' death and age at death

_____

_____

Social and Occupational History:

Job description: _____

Work schedule: _____

Recreational activities: _____

Lifestyle:

Hobbies: _____

Level of Exercise: _____

Alcohol Use: _____

Tobacco Use: _____

Drug Use: _____

Diet: _____

Medications: Please list medications taken and reason for taking.

_____

_____

_____

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Patient Name: _____

REVIEW OF SYSTEMS

1. Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

2. Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____ □ None of the above

3. Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Other _____ □ None of the above

4. Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes □ Other _____ □ None of the above

5. Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

6. Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

7. Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia □ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use □ Other _____ □ None of the above

8. Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

9. Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

10. Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Deep Wellness Chiropractic / Dr. Frederick Kennedy, Chiropractor** for services performed.

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Patient Name: _____

HISTORY OF CURRENT CONCERN

Health Concern (Symptom): _____

(Please use a separate CURRENT CONCERN HISTORY *for each major symptom.)*

Where on or in your body is the symptom, the location?

Head **N**eck **U**pper-back **M**id-back **L**ower-back **P**elvis **T**ail-bone **A**bdomen

Shoulder **E**lbow **W**rist **H**and **H**ip **T**high **K**nee **L**ower-leg **A**nkle **F**oot

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom *most* of the time: **1 2 3 4 5 6 7 8 9 10**

What percentage of the time you are awake do you experience the above symptom at the above intensity:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Did the symptom begin? (circle one) **S**uddenly **G**radually

When did the symptom begin? _____

How did the symptom begin? _____

What makes the symptom worse? (circle all that apply):

Nothing **A**ny movement **B**ending neck forward **B**ending neck backward **T**ilting head to left **T**ilting head to right **T**urning head to left **T**urning head to right **B**ending forward at waist **B**ending backward at waist **T**ilting left at waist **T**ilting right at waist **T**wisting left at waist **T**wisting right at waist **D**riving **S**tanding **W**alking **R**unning **L**ifting **S**itting **G**etting up from seated position **C**hewing **C**hanging positions **L**ying down **R**eading **W**orking **E**xercising **L**aying on side in bed **O**ther (please describe):_____

What makes the symptom better? (circle all that apply):

Nothing **R**esting **I**ce **H**eat **S**tretching **E**xercise **W**alking **P**ain medication **M**uscle relaxers **C**hiropractic adjustments **M**assage **O**ther (please describe):_____

Describe the quality of the symptom (circle all that apply):

Sharp **D**ull **A**chy **B**urning **T**hrobbing **P**iercing **S**tabbing **D**eep **N**agging **S**hooting **S**tinging **S**tiff **O**ther (please describe): _____

Does the symptom radiate to another part of your body (circle one): **Y**es **N**o

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (please circle)

No difference **M**orning **A**fternoon **E**vening **N**ight **O**ther: _____

Have you received treatment for this condition and episode prior to today's visit?

None **A**nti-inflammatory meds **P**ain medication **M**uscle relaxers **T**rigger point injections **C**ortisone injections **S**urgery **M**assage **P**hysical Therapy **C**hiropractic **O**ther: _____

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FUNCTIONAL RATING INDEX

In order to properly assess you condition, we must understand how much your concerns affect your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now. We may ask you to repeat this page (the Functional Rating Index only) every ten visits.

1. Pain Intensity

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep

3. Personal Care

0	1	2	3	4
No Pain No Restriction	Mild Pain No Restriction	Moderate Pain Need To Go Slow	Moderate Pain Need Assistance	Severe Pain 100% Assistance

4. Travel (driving, etc.)

0	1	2	3	4
No Pain On Long Trips	Mild Pain On Long Trips	Moderate Pain On Long Trips	Moderate Pain On Short Trips	Severe Pain On Short Trips

5. Work

0	1	2	3	4
Can Do Usual Work +	Can Do Usual Work Only	Can Do 50% Of Usual Work	Can Do 25% Of Usual Work	Cannot Work

6. Recreation

0	1	2	3	4
Can Do All Activities	Can Do Most Activities	Can Do Some Activities	Can Do Few Activities	Cannot Do Any Activities

7. Frequency of Pain

0	1	2	3	4
No Pain	Occasional Pain 25% Of The Day	Recurring Pain 50% Of The Day	Frequent Pain 75% Of The Day	Constant Pain 100% Of The Day

8. Lifting

0	1	2	3	4
No Pain Heavy Weight	Increased Pain Heavy Weight	Increased Pain Mod Weight	Increased Pain Lite Weight	Increased Pain Any Weight

9. Walking

0	1	2	3	4
No Pain Any Distance	Increased Pain One Mile	Increased Pain 1/2 Mile	Increased Pain 1/4 Mile	Increased Pain AllWalking

10. Standing

0	1	2	3	4
No Pain After Many Hours	Increased Pain After Many Hour	Increased Pain After One Hour	Increased Pain After 1/2 Hour	Increased Pain Any Standing

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CHOICES

How long do you have to come for Chiropractic visits?

It is always up to you! It is the doctor's responsibility to make the best recommendation for your healing and well-being. The number of visits recommended by the doctor is usually determined by three factors:

1. The nature and severity of the concern you have. The worse it is the longer it may take to correct it.
2. The length of time you have had the concern. The longer you have had the concern, the longer it may take to correct it.
3. Your chronological age. As we age, our bodies tend to heal more slowly. The older you are, the longer it may take to correct it.

Consider three things when making your choice of how long to continue your chiropractic care.

1. The degree of your pain and suffering.
2. Your budget considerations.
3. Your commitment to being healthy.

Chiropractic is about restoring normal function to the nervous system, not merely the relief of pain. Your general health and longevity depend on the integrity of your nervous system. Pain free is NOT the same as FULL FUNCTION. Being pain free is like observing the tip of an iceberg.

What to expect.

Generally, with **MEDICARE** and **Personal Injury** (car accident) concerns, we begin with a required thorough history and examination. For pain relief only, come until you feel better. For most patients who choose long-term correction, we begin with recommending 10 chiropractic visits (adjustments) and on the 10th visit, we repeat the outcome assessment forms and do a re-examination. Many patients are complete with their course of care at the 10th visit, and then choose either maintenance or wellness care at that point (Not covered by Medicare or PIP). Others acknowledge their progress, and choose to continue with regular frequent visits until full function is restored, proceeding with another round of 10 chiropractic visits and a re-exam.

As a Medicare or Personal Injury patient, what are your Health Goals? (circle one)

1. Pain relief only
2. Pain relief AND long-term correction
3. Pain relief, long-term correction, AND Wellness Care

Please comment: _____

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