

**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:  Full Legal Name:

Preferred Name:  Sex:  Status:  Birth Date:  Age:

Postal Address:  City:  State:  Zip:

Cell #:  Home/Work #:  Email:

Occupation:  Employer:

Emergency Contact:  Emergency Phone:

Referred By:

Ever received Chiropractic Care:  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: \_\_\_\_\_

**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:** \_\_\_\_\_

**PAST HEALTH HISTORY**

<b>Surgeries:</b>	<b>Date</b>	<b>Type of Surgery</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**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.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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.

**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 Neck Upper-back Mid-back Lower-back Pelvis Tail-bone Abdomen**  
**Shoulder Elbow Wrist Hand Hip Thigh Knee Lower-leg Ankle Foot**

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) **Suddenly Gradually**

When did the symptom begin? \_\_\_\_\_

How did the symptom begin? \_\_\_\_\_

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

**Nothing Any movement Bending neck forward Bending neck backward Tilting head to left Tilting head to right Turning head to left Turning head to right Bending forward at waist Bending backward at waist Tilting left at waist Tilting right at waist Twisting left at waist Twisting right at waist Driving Standing Walking Running Lifting Sitting Getting up from seated position Chewing Changing positions Lying down Reading Working Exercising Laying on side in bed Other (please describe):** \_\_\_\_\_

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

**Nothing Resting Ice Heat Stretching Exercise Walking Pain medication Muscle relaxers Chiropractic adjustments Massage Other (please describe):** \_\_\_\_\_

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

**Sharp Dull Achy Burning Throbbing Piercing Stabbing Deep Nagging Shooting Stinging Stiff Other (please describe):** \_\_\_\_\_

Does the symptom radiate to another part of your body (circle one): **Yes No**

If yes, where does the symptom radiate? \_\_\_\_\_

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

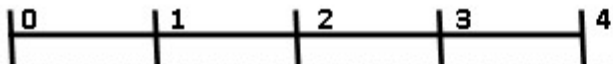
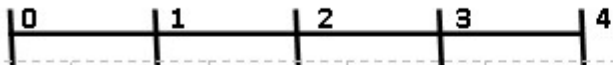
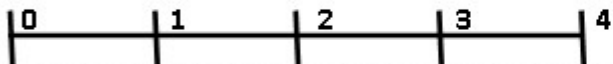
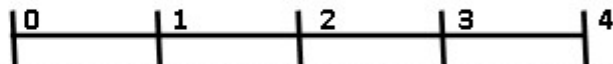
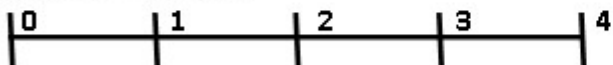
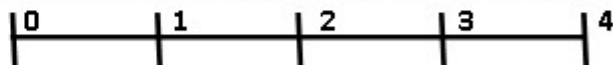
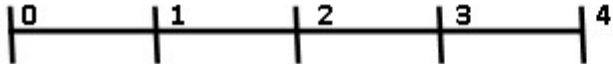
**No difference Morning Afternoon Evening Night Other:** \_\_\_\_\_

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

**None Anti-inflammatory meds Pain medication Muscle relaxers Trigger point injections Cortisone injections Surgery Massage Physical Therapy Chiropractic Other:** \_\_\_\_\_

**FUNCTIONAL RATING INDEX**

In order to properly assess your 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.

<b>1. Pain Intensity</b>  0   1   2   3   4 NO PAIN   MILD PAIN   MODERATE PAIN   SEVERE PAIN   WORST POSSIBLE PAIN					<b>6. Recreation</b>  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				
<b>2. Sleeping</b>  0   1   2   3   4 PERFECT SLEEP   MILDLY DISTURBED SLEEP   MODERATELY DISTURBED SLEEP   GREATLY DISTURBED SLEEP   TOTALLY DISTURBED SLEEP					<b>7. Frequency of Pain</b>  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				
<b>3. Personal Care</b>  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					<b>8. Lifting</b>  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				
<b>4. Travel (driving, etc.)</b>  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					<b>9. Walking</b>  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 ALL WALKING				
<b>5. Work</b>  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					<b>10. Standing</b>  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				

### 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 10<sup>th</sup> visit, we repeat the outcome assessment forms and do a re-examination. Many patients are complete with their course of care at the 10<sup>th</sup> 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: \_\_\_\_\_