Hummell Kimura Chiropractic New Patient Intake Form

Date _____

First Name _____ MI _____ Last Name _____

Date of Birth _____/_____/_____ Sex: ☐ Male ☐ Female

Leave Messages on: ☐ Home ☐ Cell ☐ Work ☐ Don't leave messages

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Email _____

Marital Status: ☐ Single ☐ Married ☐ Other

Home Address _____

City _____ State _____ Zip Code_____

Primary Care Physician _____ Phone _____

Emergency Contact _____ Relationship_____

Home Phone (_____) _____ Cell Phone (_____) _____

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other _____

Employer Name_____

Your Occupation _____

Occupational Activities: (Check one that best describes your job)

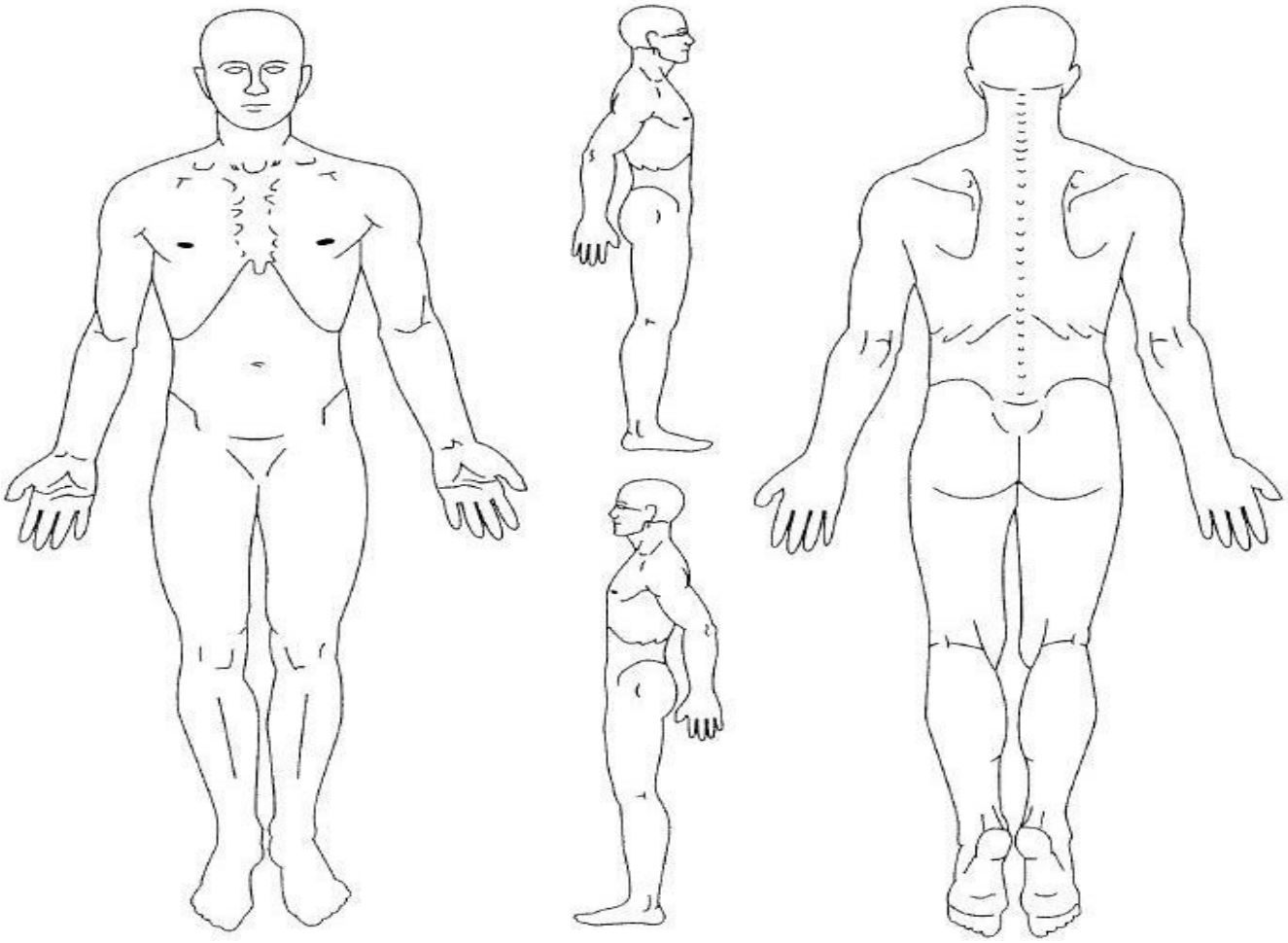
☐ Administration	☐ Business Owner	☐ Clerical/Secretary	
☐ Computer User	☐ Construction	☐ Daycare/Childcare	☐ Executive/Legal
☐ Food Service Industry	☐ Health Care	☐ Heavy Equipment operator	☐ Heavy Manual Labor
☐ Home Services	☐ Housekeeper	☐ Light Manual Labor	☐ Medium Manual Labor
☐ Manufacturing	☐ Other _____		

How did you hear about our office? □ Other □ Online □ Doctor_____

Friend/Family referral_____ _____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Sharp T=Tingling A=Dull Ache



Average Pain Intensity:

Last 24 hours: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Past week: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse

Does anything improve your pain? ☐ No ☐ Yes _____

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐ Work-related Accident ☐ Other _____

When did your symptoms begin? _____

How did your symptoms begin? _____

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)

What describes the nature of your symptoms?

☐ Sharp ☐ Ache ☐ Numb ☐ Shooting ☐ Burning

☐ Tingling ☐ Throbbing ☐ Other _____

Are You Pregnant? ☐ Yes ☐ No Pregnancy Due Date _____

Medical Conditions: (Check all that apply)

☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart Disease
☐ Hypertension ☐ Psychiatric Illness ☐ Skin Disorder ☐ Stroke
☐ Fibromyalgia ☐ Asthma ☐ Osteoporosis ☐ Other _____

Surgeries: (Check all that apply)

☐ Appendectomy ☐ Brain ☐ Breast Augmentation
☐ Cardiovascular procedure ☐ Carpal Tunnel ☐ Cervical spine ☐ Gall Bladder
☐ Gastro-intestinal ☐ Hernia ☐ Hysterectomy ☐ Joint Replacement
☐ Knee ☐ Lumbar spine ☐ Prostate ☐ Shoulder
☐ Thoracic spine ☐ Uro-genital ☐ Other _____

Allergies: (Check all that apply)

☐ Animal ☐ Chemical _____ ☐ Milk/Lactose ☐ Mold
☐ Seasonal ☐ Sulfites ☐ Wheat/Glutens ☐ Other _____

Social History: (Check all that apply)

Caffeine use: ☐ occasional ☐ often ☐ never
Drink Alcohol: ☐ occasional ☐ often ☐ never
Exercise: ☐ occasional ☐ often ☐ never
Drink Water ☐ Less than 64 oz/day ☐ More than 64 oz/day ☐ never
Cigarettes: ☐ Less than 1 pack/day ☐ More than 1 pack/day ☐ never
Sleep: ☐ Less than 8 hours/night ☐ More than 8 hours/night ☐ insomnia

Family History: (Check all that apply)

Arthritis: ☐ Parent ☐ Sibling
Cancer: ☐ Parent ☐ Sibling
Diabetes: ☐ Parent ☐ Sibling
Heart Disease: ☐ Parent ☐ Sibling
Hypertension ☐ Parent ☐ Sibling
Stroke ☐ Parent ☐ Sibling
Thyroid ☐ Parent ☐ Sibling
Other _____ ☐ Parent ☐ Sibling

Review of Systems: (Check box if you have had trouble with any of the following)

Cardiovascular	*Past*	*Present*	*No*	Respiratory	*Past*	*Present*	*No*	Allergic/Immunologic	*Past*	*Present*	*No*
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing				Eyes	*Past*	*Present*	*No*
Pace Maker								Glaucoma			
Jaw Pain								Double Vision			
Irregular Heartbeat								Blurred Vision			
Swelling of legs											
Genitourinary	*Past*	*Present*	*No*	Hematologic	*Past*	*Present*	*No*	Ear, Nose and Throat	*Past*	*Present*	*No*
Kidney Disease				Hepatitis				Difficulty Swallowing			
Burning Urination				Blood Clots				Dizziness			
Frequent Urination				Cancer				Hearing Loss			
Blood in Urine				Bruising				Sore Throat			
Kidney Stones				Bleeding				Nosebleeds			
Lower Side Pain				Fever, Chills				Bleeding Gums			
				Sweating				Sinus Infections			
				Varicose Vein							
Neurologic	*Past*	*Present*	*No*	Musculoskeletal	*Past*	*Present*	*No*	Gastrointestinal	*Past*	*Present*	*No*
Stroke				Gout				Gall Bladder Problems			
Seizures				Arthritis				Bowel Problems			
Head Injury				Joint Stiffness				Constipation			
Brain Aneurysm				Muscle Weakness				Liver Problems			
Numbness				Osteoporosis				Ulcers			
Severe Headaches				Broken Bones				Diarrhea			
Pinched Nerves				Joints Replaced				Nausea/Vomiting			
Parkinson's				Neck Pain				Bloody Stools			
Carpal Tunnel				Low Back Pain				Poor Appetite			
Vertigo				Upper Back Pain							
Constitutional	*Past*	*Present*	*No*	Endocrine	*Past*	*Present*	*No*	Psychiatric	*Past*	*Present*	*No*
Weight Loss/Gain				Thyroid				Depression			
Low Energy Level				Diabetes				Anxiety			
Difficulty Sleeping				Hair Loss				Stress			
				Menopausal							
				PMS							

Please list all current medications being taken _____

_____

_____

Hummell Kimura Chiropractic Consent to Chiropractic Services

Payment and Insurance

I understand and agree that the health and accident policies are an arrangement between the insurance carrier and myself. This office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Initials: _____

MINOR CHILD - Consent to Treatment

If applicable, I authorize the licensed doctor to administer chiropractic care as deemed necessary to my (relationship)_____ (name)
_____.

Parent Initials:_____

Patients' Rights

Hummell Kimura Chiropractic respects the unique differences of our patients and will ensure that health care ethics are maintained for all patients. The following rights will be exercised on our patients' behalf.

1. The patient has the right to considerate and respectful care.
2. The patient has the right to and is encouraged to obtain from his/her doctor and staff relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
3. The patient has the right to know the identity of everyone involved in his/her care.
4. The patient has the right to make decisions about the plan of are prior to and during the course of treatment and to refuse a recommended treatment of plan of care to the extent permitted by law, and to be informed of the consequences of this action.
5. The patient has the right to every consideration of privacy.
6. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases when reporting is permitted or required by law.
7. The patient has the right to expect reasonable continuity of care when appropriate and to be informed of available and realistic patient care options.

Patient Initials: _____

Consent to Chiropractic Services

I hereby request and consent to chiropractic manipulations and procedures including various modes of treatment by Hummell Kimura Chiropractic.

I will have an opportunity to discuss with the doctor the nature and purpose of treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks of treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgement during the course of any treatment the doctor feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content, and by signing below, I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this office.

Signed_____ Date_____

Hummell Kimura Chiropractic Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____

Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Dated this _____ day of _____, 20_____

By_____

Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____

Signature of Parent/Guardian (circle one)

Names of persons with whom you wish to share Protected Health Information:

_____

_____

_____

_____