

# Kinetic Spine & Sports New Patient Intake Form

## Patient Data

Date

**Title:** (Check one)    Mr.    Mrs.    Ms.    Miss    Dr.    Other \_\_\_\_\_

**First Name** \_\_\_\_\_ **Middle Initial** \_\_\_\_ **Last Name** \_\_\_\_\_

**Address Line 1** \_\_\_\_\_

**Address Line 2** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Home Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_    **Work Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Cell Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_    **Email** \_\_\_\_\_

**Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_    **Sex:**    Male    Female

**Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_    **Marital Status:**    Single    Married    Other

## Spouse Data

**First Name** \_\_\_\_\_ **Middle Initial** \_\_\_\_ **Last Name** \_\_\_\_\_

**Home Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_    **Work Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## Employer Data

**Employment Status:**    Employed    Unemployed    FT Student    PT Student    Other\_\_\_\_\_

**Your Occupation** \_\_\_\_\_    **Your Employer** \_\_\_\_\_

## Emergency Contact

**Contact Name** \_\_\_\_\_    **Relationship to Patient** \_\_\_\_\_

**Contact Home Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_    **Cell Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Patient Name**

**Date**

**How did you hear about our office?** \_\_\_\_\_

**Medical Conditions:** (Check all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____			

**Surgeries:** (Check all that apply to you)

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

**Allergies:** (Check all that apply to you)

Eggs	Fish and Shellfish	Milk or Lactose	Peanuts
Soy	Sulfites	Wheat/Glutens	Other _____

**Social History:** (Check all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Chew Tobacco:	occasional	often	never
Cigarettes:	<1 pack/day / >1 pack/day	never	
Wear Seat Belts:	occasional	always	never
Other _____			

**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 _____		

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

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

Other \_\_\_\_\_

**Patient Name**

**Date**

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

<b>Cardiovascular</b>	Past	Present	No	<b>Respiratory</b>	Past	Present	No	<b>Allergic/Immunologic</b>	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							
Pace Maker								<b>Ear, Nose and Throat</b>			
Jaw Pain /TMJ				<b>Eyes</b>					Past	Present	No
Irregular Heartbeat					Past	Present	No	Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
<b>Genitourinary</b>				Blurred Vision				Sore Throat			
	Past	Present	No					Nosebleeds			
Kidney Disease				<b>Psychiatric</b>				Bleeding Gums			
Burning Urination					Past	Present	No	Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				<b>Gastrointestinal</b>			
Kidney Stones				Stress					Past	Present	No
Lower Side Pain								Gall Bladder Problems			
				<b>Endocrine</b>				Bowel Problems			
<b>Neurologic</b>					Past	Present	No	Constipation			
	Past	Present	No	Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				<b>Hematologic</b>							
Pinched Nerves					Past	Present	No	<b>Musculoskeletal</b>			
Parkinson's				Hepatitis					Past	Present	No
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
<b>Constitutional</b>				Bleeding				Muscle Weakness			
	Past	Present	No	Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Please list all current medications being taken \_\_\_\_\_

\_\_\_\_\_

**Patient Name** \_\_\_\_\_

**Date** \_\_\_\_\_

Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

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

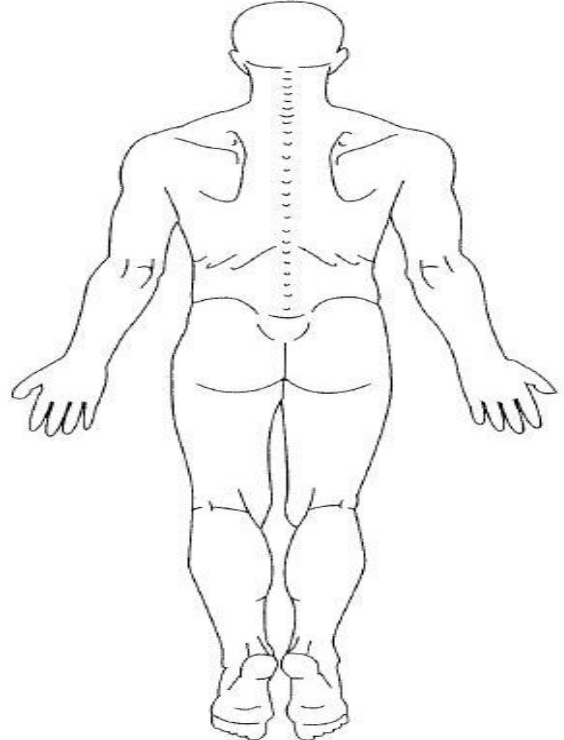
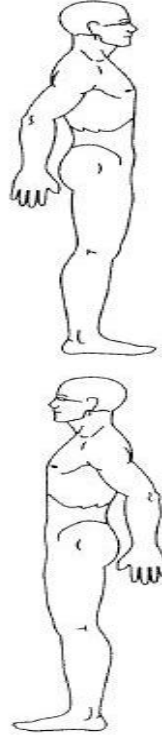
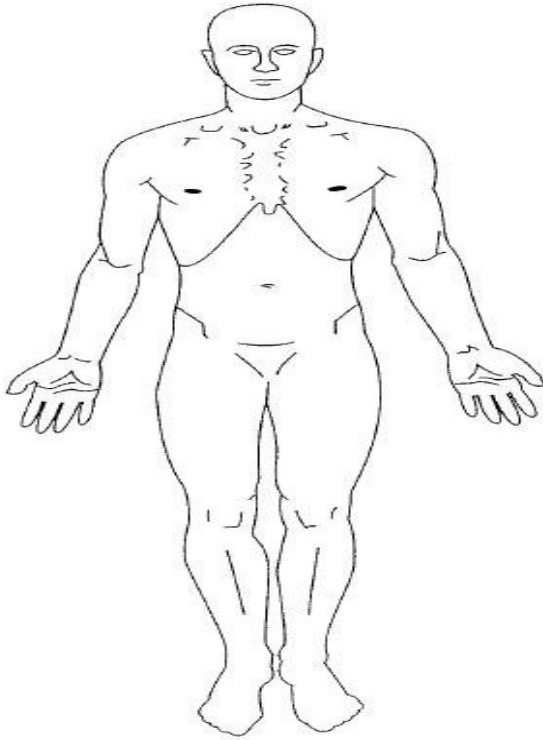
**N=Numbness**

**B=Burning**

**S=Stabbing**

**T=Tingling**

**A=Dull Ache**



Describe your symptoms in order of severity, with worse symptom being #1: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

When did your symptoms begin?      **Month** \_\_\_\_\_      **Day** \_\_\_\_\_      **Year** \_\_\_\_\_

Are your symptoms a result of:      Motor Vehicle Accident      Work related Accident      Other \_\_\_\_\_

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  
Burning

Dull ache  
Tingling

Numb  
Stabbing

Other \_\_\_\_\_

Shooting

**Patient Name**

**Date**

**How are your symptoms changing?**

Getting better

Not changing

Getting worse

**Employment, ADL, and Recreation Information**

**Description of Work:** \_\_\_\_\_

**Condition's Effect On Job Performance:**  **No Effect**                       **Mild** (painful can do)       **Mod** (painful limited ability)  
 **Mod/Sev** (limited duty)    **Sev** (no limited duty)       **Sev** (can't do limited duty)

**Daily Activities: Effects of Current Condition on Performance**

- Bending:                       **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Care –Infirm Family:     **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Carrying Groceries:       **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Change Posn–Sit–Stand:  **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Climb Stairs:               **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Driving:                      **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Extended Computer Use:  **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Feeding:                     **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Household Chores:         **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Kneeling:                    **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Lift Children:               **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Lifting:                      **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Pet Care:                    **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Reading (Concentration):  **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Self Care–Bathing:         **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Self Care–Dressing:       **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Self Care–Shaving:        **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Sexual Activities:          **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Sleep:                       **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Static Sitting:              **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Static Standing:           **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Walking:                    **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform
- Yard Work:                  **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (Limited)    **Sev** Unable to Perform

**Recreational Activity: Effects of Current Condition on Performance**

- \_\_\_\_\_  **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (limited)    **Sev** Unable to Perform
- \_\_\_\_\_  **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (limited)    **Sev** Unable to Perform
- \_\_\_\_\_  **No Effect**    **Mild** Painful (Can do)    **Mod** Painful (limited)    **Sev** Unable to Perform

This form is designed to inform you in advance of our policies for payments, insurance claims, and third party payment responsibilities. Please refer any questions that you may have to the front desk receptionist. Please read, initial, and sign below.

Initial

\_\_\_\_\_ Payment for co-pays, co-insurance and deductibles is expected at the time of service. We accept cash, check, MasterCard, American Express and Visa. A \$35.00 service charge will be applied to all returned checks. Payment for any returned check must be in cash and include the \$35.00 fee.

\_\_\_\_\_ Insurance is a contract between you and your insurance company. As a courtesy to you, we will bill your health insurance carrier. You are responsible for any and all co-pays, co-insurance, non-covered services and deductibles.

\_\_\_\_\_ A summary of the Privacy Notice (HIPAA) has been made available to me and I understand my rights. By way of my signature, I provide Kinetic Spine & Sports with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Notice.

\_\_\_\_\_ At Kinetic Spine & Sports our major concern is to assist you in maintaining overall good health. However, your insurance company may only approve those visits necessary to improve your symptoms. Once we have reduced your symptoms your insurance may no longer pay for any additional care. Often it is beneficial for the patient to continue supportive care. In such case, you, the patient, may be financially responsible.

\_\_\_\_\_ We are happy to provide treatment for accident victims and those who are involved in liability cases. All information must be given to our office immediately following the accident. You must provide us with any and all attorney, liability, med-pay, and Health Insurance Information.

\_\_\_\_\_ In the case of minors, it is the responsibility of the accompanying legal guardian to approve in advance and pay for treatments. The guardian is also responsible for making sure the patient account is kept current.

I have read and understand the above information. By signing below I consent to treatment and agree to the terms listed above.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Payment/Insurance Information:**

Who is responsible for your bill?      Self      Health Insurance      Spouse      Worker's Comp  
Auto Insur.      Medicare      Medicaid      Other \_\_\_\_\_

Personal Health Insurance Carrier: \_\_\_\_\_ Insur. Card ID # \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_      Primary Care Physician \_\_\_\_\_

**Worker's Compensation Injury / Auto / Personal Injury:**

Have you filed an injury report with your employer?    Yes    No    Date: \_\_\_\_/\_\_\_\_/\_\_\_\_    Time: \_\_\_\_\_ am / pm

**HIPAA Privacy Practices**

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name \_\_\_\_\_

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

Consent to Treat a Minor: (Minor's Printed Name) \_\_\_\_\_

Guardian / Spouse's Signature Authorizing Care \_\_\_\_\_

Date \_\_\_\_\_

**SIGNATURE OF PHYSICIAN: \_\_\_\_\_ Date: \_\_\_\_\_**