ACCT# _____ PATIENT INFORMATION

PLEASE ANSWER ALL QUESTIONS COMPLETELY AND ACCURATELY. PLEASE PRINT.

Patient:

Full Name _____ Preferred Name _____ Sex: M F

Home Phone _____Cell Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip Code _____

Age _____ Birth Date _____ Marital Status (Circle One) S M W D Sep Number of Children ____

SSN# _____-____-_____ Driver's License Number _____

Email Address _____

Employer _____ Occupation _____ Number of Years _____

Employer Address _____ City _____ State ____ Zip Code _____

Insurance:

Do you have Health Insurance? Yes ____ No ____ Are you the subscriber? Yes ____ No ____

Name of subscriber (if not you) _____ Subscriber Date of Birth _____

Insurance Company _____

Subscriber ID# _____ Plan/Group# _____

Is your condition today due to an accident? Yes ____ No ____ Date of Accident _____

How did you find out about our office?

Many of our patients find us because someone referred them here. If someone referred you, please leave their name so we can give them a thank you gift!

☐ Friend or family recommendation. Name _____ ☐ Doctor referral. Name _____
☐ Google Search ☐ Facebook ☐ Mailer/Postcard ☐ Drove By ☐ Other _____

In case of Emergency:

Name of Spouse, Parent or Guardian, or other Emergency Contact:_____

Contact's Employer _____ Contact's Phone Number _____

I agree that a photo static copy of this agreement shall serve as the original.

Patient or Guardian Signature _____ Date _____

****Notice to our new patients: Full payment for services rendered is due at the end of each visit****

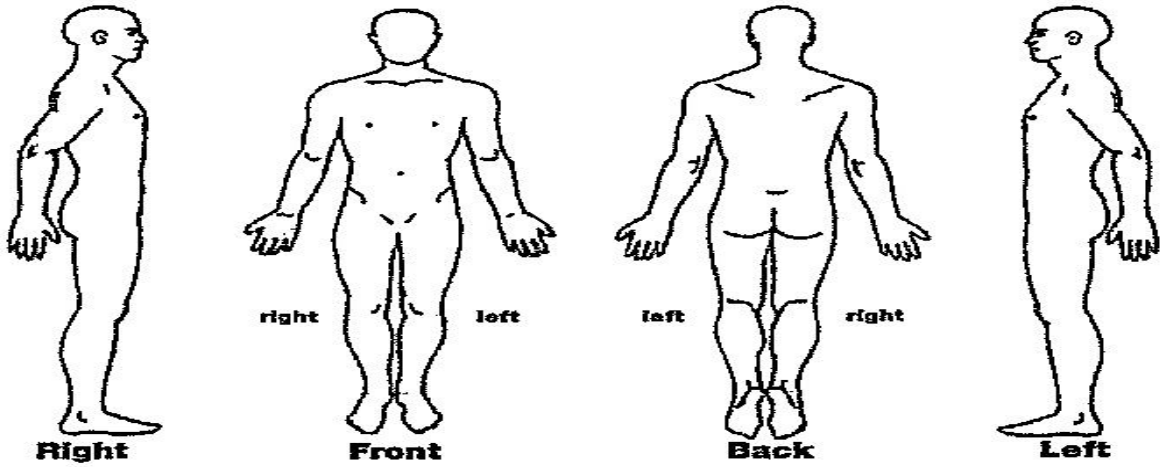
Problem Focused History

Name _____ Age _____ Sex: M F Date _____

What brings you into our office today? (Please Explain) _____

_____

Please indicate the location of your symptoms, injury or pain:



1. When did your symptoms start? _____
2. How did your symptoms start? _____
3. Rate your pain or symptoms on a scale of 1-10, 1 is barely noticeable, and 10 is emergency-room level pain or symptoms
   1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
4. Has your pain spread or radiated anywhere: Yes____ No ____
   If so where? _____
5. Have your symptoms changed since onset? Yes ____ No ____
   Decrease ____ Increased ____ Come and Go ____
6. Have you noticed any change in bodily functions? Yes ____ No ____ (Please check those that apply)
   ____ Balance/coordination ____ Bowel Habits ____ Breathing ____ Hearing
   ____ Coughing/sneezing ____ Walking ____ Grip Strength ____ Menstrual
   ____ Sexual ____ Urination ____ Vision ____ Weakness
7. Handedness: Right ____ Left ____ Ambidextrous ____
8. This issue is affecting my:
   ____ Childcare ____ Job ____ Marriage ____ Finances
   ____ Exercise ____ Hobby ____ Stress Level ____ Mood
   Please identify up to 3 activities that you are unable to do or are having difficulty with as a result of this issue:
   1. _____
   2. _____
   3. _____

9. Work Status: Full Time ____ Student ____ Unemployed ____ Retired ____ Disabled _____
10. Work/Home Disability: Yes ____ No ____
    Complete: ____ Days off work
    ____ Days unable to perform Household tasks
    ____ Days of job modification
    ____ Days of decreased household tasks
11. Have you been treated by anyone else for this problem? Yes ____ No ____
    If so, please identify who and what type of therapy? _____
    _____
12. Are you currently under a doctor's care for any <u>other</u> conditions? Yes ____ No ____
    If so, please explain: _____
13. Have you suffered any physical injuries such as falls or blows, whiplash, concussion, or head injury, lacerations, sprains, strain, dislocations, broken or cracked bones? Yes ____ No ____
    Please explain: _____
14. Please list any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):
    1. _____ Date _____
    2. _____ Date _____
    3. _____ Date _____
    4. _____ Date _____
15. Have you ever been hospitalized for any reason other than surgery? Yes ____ No ____
    Explain: _____
16. Do you have any nervous system diseases and/or mental health problems? Yes ____ No ____
    Explain: _____
17. Do you have any muscle, tendon or ligament problems (ex. arthritis, osteoporosis etc.)?
    Yes ____ No ____ Explain: _____
18. Do you have any gland or hormone problems? Yes ____ No ____ Explain: _____
19. Have you ever had cancer? Yes ____ No ____ Explain Type: _____
20. Have you lost weight without trying? Yes ____ No ____ How much? _____
21. Does your pain wake you up at night? Yes ____ No____
22. Have you recently had any unusual bleeding or discharge? Yes ____ No ____
23. Medications: Please list all medications (prescription and non-prescription) you are currently taking or take on an occasional basis:
    1. _____ Dose _____ Frequency _____
    2. _____ Dose _____ Frequency _____
    3. _____ Dose _____ Frequency _____
    4. _____ Dose _____ Frequency _____
    5. _____ Dose _____ Frequency _____
24. Do you have any allergies to medication? Yes ___ No ___ Explain: _____
25. Are there any diseases or conditions that are common among your family members (I.E. Inherited diseases or conditions, Mother, Father, Maternal Grandparents, or Paternal Grandparents)? Yes ____ No ____ If yes, please explain: _____
    _____
26. **Do you have a Pacemaker or any other Surgically Implanted Device? Yes ____ No ____**
27. **Females: Are you now or could you be pregnant? Yes ___ No ___**
    Date of last menstrual cycle _____ Are you on birth control? Yes ___ No ___

Anything else that you would like to tell us, please do so here: _____
_____
_____

Medical History

Indicate any of the following you have experienced in the PAST FEW WEEKS

☐ Dizziness	☐ Shoulder Pain	☐ Abdominal Pain
☐ Angina (chest pain)	☐ Elbow pain	☐ Allergies
☐ Headache	☐ Hand Pain	☐ Irritable Bowel
☐ Visual changes	☐ Wrist Pain	☐ Constipation
☐ Kidney Stones	☐ Hip Pain	☐ Diarrhea
☐ Complete loss of bowel or bladder control	☐ Jaw Pain	☐ Nausea
☐ Drug Abuse	☐ Knee pain	Male Only
☐ Fever	☐ Neck Pain	☐ Testicular pain
☐ Head Trauma	☐ Ankle Pain	☐ Groin Pain
☐ Leg or arm weakness	☐ Back Pain	Female Only
	☐ Foot Pain	☐ Abnormal/painful menstruation

Indicate which of the following you have EVER had

☐ Stroke	☐ High Cholesterol	☐ Epilepsy
☐ Unexpected weight loss	☐ Gout	☐ Lupus
☐ Spinal Surgery	☐ Hormone therapy	☐ Hypothyroidism
☐ Fractured Vertebrae	☐ Inflammatory Bowel Disease	☐ Hyperthyroidism
☐ Cancer _____	☐ Liver Condition	☐ Bleeding Disorder
☐ Kidney Stones	☐ Gallbladder Condition	☐ Ulcer
☐ Rheumatoid Arthritis	☐ Mental Illness	☐ Herniated discs
☐ Arthritis	☐ Prostatitis (male only)	☐ Bulging discs
☐ Psoriasis	☐ Neurological Disorder	☐ Varicose Veins
☐ HIV / AIDS	☐ Diabetes	☐ Numbness
☐ Tumor	☐ Sinus Condition	☐ Other health condition: _____
☐ Heart Disease	☐ Depression	
☐ High Blood Pressure		

Please list any supplements you take: _____

_____

Current Dietary Restrictions / food allergies: _____

Current Exercise habits: _____

In an effort to keep your health information up to date and to keep your Primary Care Physician (PCP) informed of the health care you receive in our office we are requesting your authorization to release your health records to your PCP.

PCP Name: _____

PCP Practice Name: _____

PCP Phone Number: _____

Your Signature: _____

Kauffman Chiropractic LLC
215 Loveland- Madeira Road Loveland, OH 45140 513-444-4529

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Kauffman Chiropractic LLC.

I understand that the Notice describes the uses and disclosures of my protected health information by Kauffman Chiropractic LLC and informs me of my rights with respect to my protected health information.

Please indicate other people (a spouse, significant other, or relative) you will allow this clinic to share aspects of your treatment and protected health information (including your medical information, billing information and/or scheduled appointments). You may choose to allow none.

Authorization to Release Information

	Name	Relationship	Phone
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Please indicate if you allow this clinic to leave information about your medical information, billing, and scheduled appointments (protected health information) in a voicemail or email as needed. Please initial each that you allow. You may choose to allow none.

Text: Y / N (appointment reminders) **Voicemail: Y / N** **Email Y / N**

Phone Number:_____ Email Address: _____

_____ _____

Patient's Signature *or that of Legal Representative*

Printed Name *of Patient or that of Legal Representative*

_____ _____

Today's Date

If Legal Representative, Indicate Relationship

Kauffman Chiropractic LLC
215 Loveland- Madeira Road Loveland, OH 45140 513-444-4529

OFFICE POLICY LETTER

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGE FOR OFFICE VISITS (INCLUDING DEDUCTIBLES, CO-PAYS, AND CO-INSURANCE) BE PAID AT THE CONCLUSION OF EACH VISIT.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, co-pay or any other balance not paid by your insurance.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, Medicaid and other health plans to: Kauffman Chiropractic 215 Loveland-Madeira Rd. Loveland, OH 45140.

I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

To the extent necessary to determine liability for payment, and to obtain reimbursement, I authorize disclosure of portions of any medical records.

In the event that full payment for charges incurred connection with my medical care is not made, I agree to pay all costs of collection, including reasonable attorneys' fees. I also agree to submit myself to the jurisdiction of the courts of Hamilton County, Ohio.

This agreement will remain in effect until revoked by me in writing. A photocopy of the assignment it to be considered as a valid as the original. I may request a copy of the assignment at any time.

SIGNED_____ DATE_____
Responsible Party's Signature

Kauffman Chiropractic LLC
215 Loveland- Madeira Road Loveland, OH 45140 513-444-4529

Informed Consent

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document, so please ask us if you have any questions.

The nature of the chiropractic adjustment: The primary treatment used by Doctors of Chiropractic is spinal manipulative therapy. We will use that procedure to treat you. We may utilize hands-on or mechanical instrument manipulations to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement. Common benefits of the above treatment include improved mobility and reduced pain.

Analysis/ Examination/ Treatment:
As a part of the analysis, examination, and treatment, you are consenting to the following procedures as they are recommended for you: spinal manipulative therapy, palpation, vital signs, orthopedic and basic neurological testing, range of motion, muscle strength testing, postural analysis, ultrasound, hot/cold therapy, radiographic studies, electrical muscle stimulation, dry needling (piercing the skin with fine-gauge needles), spinal decompression therapy (traction), rehabilitation stretching and strengthening, nutritional analysis/therapy, massage therapy, muscle therapy, and other treatments and tests as deemed necessary.

The material risks inherent in chiropractic treatment:
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation (CMT) and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strains, cervical myelopathy, pneumothorax, bruising, burns, and infection or blood-borne illness. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke. Chiropractic is a safe and comfortable form of health care for most people. If a potential risk is identified, you will be informed and offered either treatment or a referral to the appropriate health care specialist for evaluation and care. If you have a condition that would otherwise not come to the doctor's attention it is your responsibility to inform the doctor.

The probability of those risks occurring:
Fractures caused from spinal manipulation are extremely rare. Patients suffering from bone weakening conditions like osteoporosis are in a higher risk category. Alternative forms of spinal manipulation may be utilized for these patients. **Please inform the doctor if you have a bone weakening disease.** Researchers have found no evidence of excess risk of VBA stroke associated with chiropractic care compared to primary care. However, if there is a causal relationship between manipulation and stroke, it is rare and remote. **Please inform us of any personal or family history of stroke.** There have been some reports of herniated or ruptured discs caused by spinal manipulation or mechanical traction. In rare circumstances dry needling has been reported to cause pneumothorax and infection. We practice evidence-based manipulation procedures and follow guidelines for all therapies to minimize risk. The risk of all other complications (material risks) mentioned above are rare, but it is not uncommon to experience minor soreness following the initial treatments.

The availability and nature of other treatment options:
One of the most common treatment options for the conditions we treat is self-administered, over-the-counter medications such as NSAIDs. Spinal manipulation is significantly safer than NSAIDS when comparing risk of adverse events. Prescription oral medications, injections, and surgical interventions are other treatment options that commonly carry significant risk.

The risks and dangers of conditions remaining untreated or undertreated:
Early intervention to restore normal function and compliance with the treatment plan are both essential in an effort to prevent conditions from progressing to a further chronic pain/symptom state.

Kauffman Chiropractic LLC
215 Loveland- Madeira Road Loveland, OH 45140 513-444-4529

Consent to Treat a Minor (Required for all patients under 18 years old)

I hereby request and authorize this clinic to perform diagnostic tests and render treatment to my minor (son/daughter/other) _____. This authorization extends to all doctors and staff members and includes radiographic examination at the doctor's discretion. As of this date, I have the legal right to select and authorize health care services for the minor named above. Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or parent is not required. If my authority to select and authorize this care should be revoked or modified in any way I will immediately notify this office. I also consent to the minor listed above to be treated without me present in the office.

ALL PATIENTS:

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read [ ] or have had read to me [ ] the above explanation of the examination and treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the benefits, risks, and alternatives, I hereby give my consent to all examination, testing, and treatment described above.

Patients Name: _____ Doctors Name: _Dr. David Kauffman, DC__

Signature: _____ Signature: _____

Dated: _____ Dated: _____

Signature of Parent or Guardian (if the patient is a minor) _____