McKolosky Chiropractic

Patient Name: _____	Home Phone: _____
Address: _____	Cell Phone: _____
Date of Birth: _____	Would you like text Reminders for appts? Y N
Height: _____ft_____inches	Email: _____
Weight: _____lbs	Work Phone: _____
Marital Status: M S W D	Employer: _____
Referred By? : _____	Occupation: _____
Have you had xrays recently? Y N	Emergency Contact : _____
If yes, Where?_____	Relationship:_____ Phone#:_____

Chief Complaint: _____

When did this condition begin? _____

Has it ever occurred before? Y N If yes, when? _____

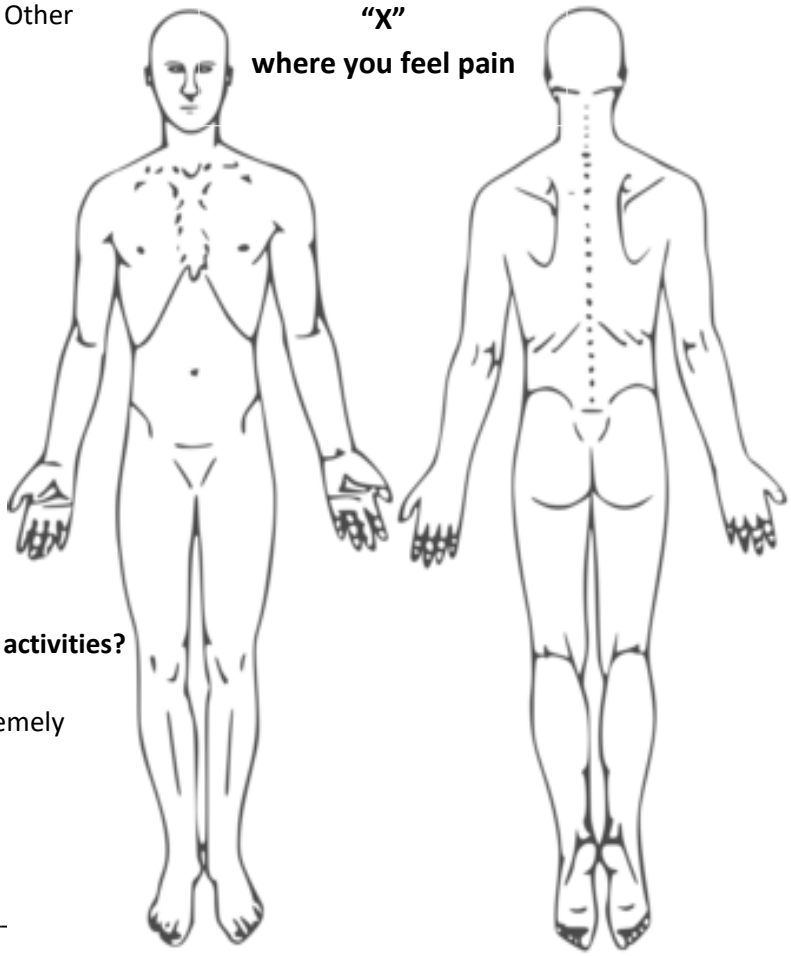
Briefly describe your symptoms: _____

How did your symptoms start? _____

Is this Condition: ☐ Auto Related ☐ Job Related ☐ Home Injury

☐ Slip or Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause ☐ Other

Mark with an "X" where you feel pain



Average Pain Intensity: (0 = no pain 10 = worst pain)

At Rest: 0 1 2 3 4 5 6 7 8 9 10

During Activity: 0 1 2 3 4 5 6 7 8 9 10

How often do you experience symptoms?

☐ Constantly (76-100% of the time)

☐ Frequently (51-75%)

☐ Occasionally (26-50%)

☐ Intermittently (0-25%)

How much have your symptoms interfered with your usual daily activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No

If yes, who? _____

Please list any medications you are currently taking and WHAT FOR…	☐ Not currently prescribed any medication

Allergic to any medication (s)?:_____

Smoking Status

☐ Current every day smoker
☐ Current some day smoker
☐ Former Smoker
☐ Never smoker

Use

☐ Tobacco
☐ Alcohol
☐ Coffee

DISEASE/CONDITION (Please circle the appropriate answer)

Arthritis	Self	Mother	Father
Osteoarthritis	Self	Mother	Father
Osteoporosis	Self	Mother	Father
Rheumatoid Arthritis	Self	Mother	Father
Fibromyalgia	Self	Mother	Father
Asthma	Self	Mother	Father
Heart Disease	Self	Mother	Father
High Blood Pressure	Self	Mother	Father
Thyroid disease	Self	Mother	Father
Diabetes	Self	Mother	Father
Kidney Disease	Self	Mother	Father
Autoimmune	Self	Mother	Father
Cancer	Self	Mother	Father
Other	Self	Mother	Father

Please list any major surgeries below ****Include any electronic devices implanted****	Date

Assignment of Benefits

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with _____ and hereby assign and convey directly to McKOLOSKY CHIROPRACTIC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer, and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement, or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement, and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have read and fully understand this agreement:

_____ _____

Signature of Insured/Guardian Date

Consent to Treat

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read below and if you have any questions please feel free to ask one of our staff members.

INFORMED CONSENT:

A patient, in coming to MCKOLOSKY CHIROPRACTIC, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The Doctor of Chiropractic provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient at MCKOLOSKY CHIROPRACTIC, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

I, _____, have read and fully understand the above statements.

Patient Signature: _____

Date: _____

Consent to Evaluate and Treat a Minor

I,_____, being the parent or legal guardian of _____, have read the above consent and hereby grant permission for my child to receive chiropractic care.

Date: _____

Healthcare Communication

In the event that we would need to communicate your healthcare information, to whom may we do so?

SPOUSE: _____

CHILDREN:_____

OTHER:_____

May we leave a message on any answering device we have on file for you? YES_____ NO_____

May we send healthcare information to your family doctor: YES_____ NO_____

FAMILY DR:_____

Patient Signature: _____

Date: _____

Pregnancy Verification

Please mark the appropriate answer below:

_____ To the best of my knowledge**, I AM PREGNANT** and I do not give my permission to have an X-Ray done.

_____ To the best of my knowledge, **I AM NOT PREGNANT** and do give my permission to have an X-Ray done.

_____ I am **NOT SURE** if I am pregnant.

Patient Signature: _____

Date: _____

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of McKolosky Chiropractic's Notice of Privacy Practices.

_____ _____

Signature of patient or personal representative Date

_____

If signed by personal representative, relationship to patient

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Office Use Only:

Our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

Patient Name:_____

Refused to sign ☐ Physically unable to sign☐

(Other)_____
_____
_____
_____

Employee Signature: _____ Date: _____