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Consent to Evaluation & Care

Purpose: To undergo a chiropractic evaluation to determine my current functional and physical abilities to perform self-care activities of daily living skills (ADL's) and/or work related tasks as they may pertain to the essential job functions for my job title and/or to undergo rehabilitative care. Additional evaluation methods may be obtained if I am seeking disability. My-self, physician, employer, attorney and/or insurance carrier may have referred me today, but is not a requirement for an appointment.

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1. I _____ authorize *KC CORE* to perform an evaluation and to provide modalities and therapeutic procedures that they may consider necessary or advisable in the course of my healthcare. All treatment procedures and a plan of care will be discussed with me prior to receiving such treatments.
2. I **DO / DO NOT** give permission for *KC CORE* staff to provide Basic Life Support (CPR/First Aid) treatment in the event that I experience life threatening symptoms such as heart attack, choking, loss of consciousness, stroke, or other significant symptoms.
3. The nature and purpose of the procedures, possible alternatives, risks involved, possible consequences and the possibility of the complications will be explained to me by the practitioner and/or his associates and assistants or in written format.
4. I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure has been given by *KC CORE*, its associates or assistants.
5. I acknowledge that my insurance benefits and any out of pocket expenses that may be owed by me have been discussed with me by a *KC CORE* representative.
6. I acknowledge that some forms of care may require that I put on a medical gown, shorts, T-shirt, or sports bra for evaluation and treatment purposes only.
7. I acknowledge that a fee in the amount of **$35.00** will be assessed in the event that I do not give a minimum of 4 hours prior notice to appointment cancellation or rescheduling.
8. In the event that your insurance has a per diem amount less than $50.00 you may be responsible for any uncovered treatment including massage, myofascial release or muscle treatment that is performed on each date of service. You may decline these extra services that are not covered by your insurance at any time.
9. For the purposes of medical documentation, security and compliance with the HIPPA Privacy Act, I understand that all information pertaining to my evaluation and treatments will become a part of my medical history chart and treated as such including but not limited to; medical history, results of this evaluation, treatment progress notes, digital photos, copies of driver's license, or medical insurance cards.
10. I understand that *KC CORE* clinical staff practices complementary and alternative healthcare services, at no time will any *KC CORE* clinical staff be responsible for any of my prescription medications prescribed by my Medical doctor. *KC CORE* will defer all medication questions and treatment plans to my Medical doctor, However, I acknowledge that I have been informed, and that before taking any nutritional supplements recommend by *KCCORE* that it is my responsibility to check with my pharmacist and primary care physician. By taking said nutritional supplements I acknowledge it is not necessarily a cure, but to assist in functional health.
    Initials_____

_____ _____

Patient/ Legal Guardian Date

_____ _____

KC CORE Representative Date

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Patient Registration

Today's Date_____

Male_____ Female_____

Name_____
First MI Last

Address_____ _____
St Apt#

_____
City State Zip

Date of birth_____/_____/_____

Home#_____

Cell # _____

Work#_____

E-mail:_____

Employer_____

_____
City State

Occupation_____

Employment Status:
□ Full-time □ Part-time
□ Unemployed □ Retired

Marital Status_____

Emergency Contact_____

Phone#_____
Relationship_____

Is it ok to leave a message on answering machine or with whoever answers at home?
Yes □ No □
Is it ok to call you at work? Yes □ No □

Insurance Information:

Policy Holder/Primary Insured:

□ **Same as Patient** (if marked, skip to next section)

Name_____
First MI Last
Male___ Female_____

Relation to patient_____

Date of Birth_____/_____/_____

Phone # _____

Employer _____

******* Additional Patient Information********

Is the condition we are treating related to current or previous employment? Yes____ No____

Is the condition we are treating related to an auto accident? Yes____ No____

Is there another health benefit plan, such as a Health Savings account? Yes____ No____

How did you hear about our office?

_____

_____

Name of Primary Care Physician: _____

PCP Clinic/Hospital: _____

PCP Phone #: _____

Specialist referred by: _____

I authorize KC CORE and the Doctors of Chiropractic doing business under such name to perform an examination on me or on

_____(For whom I am the legal representative).

Signature: _____ Date: _____

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PERSONAL CASE HISTORY

Patient's Name _____ Date _____

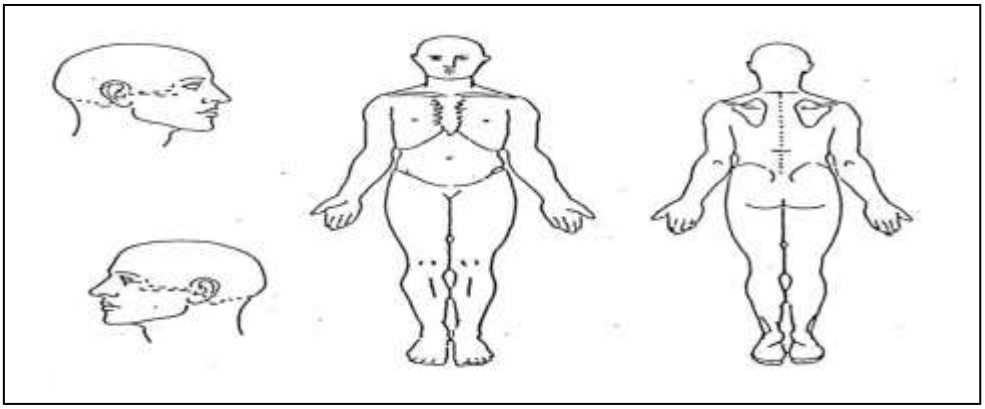
Describe the condition(s) that brought you to this office, beginning with your highest priority (1) to lowest (4):

1) _____
2) _____
3) _____
4) _____

Use these numbered descriptions below to label each area with one or more terms which best describes your condition(s).

1	Sharp Pain	7	Burning
2	Dull Pain	8	Tingling
3	Throbbing	9	Cramping
4	Numbness	10	Stiffness
5	Aching	11	Swelling
6	Shooting	12	Stabbing

Please mark your symptoms on the figures below



Circle the range to include the severity of your pain today and at its worst.

1= no pain 10= severe pain

Example	1 2 3 4 5 6 7 8 9 10
Neck	1 2 3 4 5 6 7 8 9 10
Mid-Back	1 2 3 4 5 6 7 8 9 10
Low back	1 2 3 4 5 6 7 8 9 10
Arms	1 2 3 4 5 6 7 8 9 10
Legs	1 2 3 4 5 6 7 8 9 10
Other	1 2 3 4 5 6 7 8 9 10

Does the pain extend into your arms or legs? ☐ No ☐ Yes,
Describe: _____

Do you experience your symptoms?
☐ Constantly ☐ 75% of the time ☐ 50% of the time ☐ Less than 25% of the time

Specific date or time frame your current symptoms began: __/__/____
_____

Condition Type: ☐ New ☐ Recurring ☐ Exacerbation

Has your condition: ☐ improved ☐ gotten worse ☐ stayed the same since its onset?

What makes your symptoms better? _____

What makes your symptoms worse? _____

Please describe how your symptoms started. Be as specific as possible.

_____
_____
_____
_____
_____
_____

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Patient's Name _____ Date _____

Have you been medically treated for this before? □ No □ Yes

If yes, what treatment did you receive? _____

Results of previous treatment: □ No Effect □ Temporary Relief □ Improved □ Worse

Have you tried any of the following self-help treatments?

Over The Counter Medication	□ No Effect	□ Temp Relief	□ Improved	□ Worse
Application of Ice/Heat	□ No Effect	□ Temp Relief	□ Improved	□ Worse
Physical Therapy	□ No Effect	□ Temp Relief	□ Improved	□ Worse
Massage	□ No Effect	□ Temp Relief	□ Improved	□ Worse
Exercise	□ No Effect	□ Temp Relief	□ Improved	□ Worse

Is this condition interfering with □ sleep □ lifting □ walking □ sitting □ standing □ exercise

Is this condition stopping you from doing anything in your daily life?
Explain_____

Have you been treated by a chiropractor before today? □ No □ Yes
If yes, please list name of last seen chiropractor/clinic: _____

Have you had any **surgeries** performed? □ No □ Yes
If yes, please list: _____

List all medications that you are currently taking or mark "see attached" and supply list with paperwork.

Name of medication	Purpose of medication

Are you allergic to any medication? □ No □ Yes

If yes, please list: _____

When did you last have:	Never	6 months or less?	More than 6 months ago	Unknown
- spinal x-ray?	□	□	□	□
- physical examination?	□	□	□	□

FAMILY HEALTH HISTORY: Information about your immediate family members, brothers, sisters, parents, and grandparents
If no conditions exist, please mark "N/A" on each line. If conditions are unknown, please mark "Unknown" on each line.

Relationship	**Present and past health conditions (ie: High BP, Diabetes, Cancer, Heart Issues, etc.)**
Mother	
Father	
Grandmother	
Grandfather	

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Personal Health History

Patient Name: _____ Date: _____

Height: _____ **Weight:** _____ **Smoking Status:** __**Never** __**Used to** __**Sometimes** __**Often**

Please check *yes* if you currently have or have had any of these symptoms in your life.

Please check Yes or No	Y	N	Please check Yes or No	Y	N	Please check Yes or No	Y	N
EARS / NOSE / THROAT:			Nausea or vomiting			Diabetes (insulin / non- insulin)		
Hearing loss or ringing in the ears			Frequent diarrhea			**HEMATOLOGIC/LYMPHATIC:**		
Earaches or drainage			Constipation			Slow to heal after cuts		
Chronic sinus problems			Painful bowel movements			Bleeding / bruising tendency		
Nose bleeds			Blood in stool			Anemia		
Sore throat or voice change			Abdominal pain			Blood clot		
Swollen glands in neck			Ulcer (stomach / duodenal)			**INTEGUMENTARY:**		
NEUROLOGICAL:			Indigestion / GERD			Rash or itching		
Frequent / recurring headaches			**GENITOURINARY:**			Varicose veins		
Light headed or dizziness			Frequent urination			History of cancer		
Convulsion or seizures			Burning / painful urination			**MUSCULOSKELETAL:**		
Numbness or tingling			Awaken at night with pain			Joint pain		
Stroke or head injury			Blood in urine			Joint stiffness or swelling		
PSYCHIATRIC:			Change in urine stream force			Weakness in muscles / joints		
Memory Loss or confusion			Incontinence or dribbling			Muscle pain or cramps		
Nervousness / Depression			Kidney stones			Back pain		
Difficulty sleeping			Males: Testicle pain/lumps			Difficulty walking		
CARDIOVASCULAR:			Females Only:			**EYES:**		
Hypertension (high blood pressure)			Painful periods			Eye disease or Injury		
Heart trouble			Irregular periods			Wear glasses or contact lenses		
Chest pain or angina pectoris			Vaginal discharge			Blurred or double vision		
Palpitations			Breast pain or lump					
Swelling of ankles or hands			Nipple discharge					
RESPIRATORY:			Date of last period:					
Asthma or wheezing			#of pregnancies:					
Chronic or frequent coughs			#of living children:					
Spitting up blood			Date of last pap smear:					
Shortness of breath			Date of last mammogram:					
GASTROINTESTINGAL:			**ENDOCRINE:**					
Loss of appetite			Glandular / hormone problem					
Change in bowel habits			Thyroid disease					

HIPAA PRIVACY POLICY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (i.e. my insurance company).
- The day to day healthcare operation of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: _____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____