***Whom may we thank for referring you to this office?*** _____

# APPLICATION FOR CARE AT Kimbrell Chiropractic

Today's Date: _____

## PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: ____ Zip: _____

E-mail Address: _____ Home Phone: _____Mobile Phone: _____

Work Phone: _____ Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____ __

Number of children and Ages: _____

Name & Number of Emergency Contact: _____ ___ Relationship: _____

## HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: **Primarily**: _____

**Secondary**: _____ **Third**: _____ **Fourth**: _____

From **1** to **10** with **10** being the worst pain and **0** being no pain, rate your above complaints by c***ircling the number*****:**

**Primary** or chief complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Second** complaints: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Third** complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Fourth** complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐AM ☐ PM ☐ Mid-day ☐ Late PM

How long does it last?

☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

**How did the injury happen?**_____

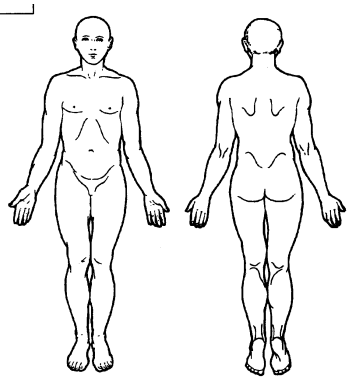
Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ ☐ **N/A**

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

**R = R**adiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling



What relieves your symptoms? _____ What makes them feel worse? _____

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| **LIST RESTRICTED ACTIVITY:** | **CURRENT ACTIVITY LEVEL** | **USUAL ACTIVITY LEVEL** |
|---|---|---|
| **Example: sitting, driving, walking** | **Example: 5 minutes before painful** | **30 minutes / unlimited** |
| _____: | _____ | |
| _____: | _____ | |
| _____: | _____ | |
| _____: | _____ | |

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

## PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes **If yes** how many times? _____ __

When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____ and who provided it: _____ **How long ago? _____** What were the results. ☐ Favorable ☐ Unfavorable please explain. _____ _____

Please identify any and all types of allergies you have had in the past or present :

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have and **N** for *N**ever** have had***:**

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer

___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions:

**PLEASE identify ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem:

| | HOW LONG AGO | TYPE OF CARE RECEIVED | BY WHOM |
|---|---|---|---|
| **INJURIES** | | | |
| **SURGERIES** | | | |
| **CHILDHOOD DISEASES** | | | |
| **ADULT DISEASES** | | | |

## SOCIAL HISTORY

Smoking: ☐cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Alcoholic Beverage consumption: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Hobbies/ Recreational Activities/ Exercise Regime: How does your present problem affect the following:

☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

## FAMILY HISTORY:

Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes

If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ Sister ☐ Brother ☐ Son(s) ☐ Daughter(s)

Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

I hereby authorize payment to be made directly to **181 Chiropractic**, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to [for any and all services I receive at this office.

Patient's Name: _____

_____ _____/_____/_____

Patient or Authorized Person's Signature Date

_____ _____/_____/_____

Doctor's Signature Date Form Reviewed

# ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

| ACTIVITIES | EFFECT | | | |
|---|---|---|---|---|
| Carrying Groceries | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sit to Stand | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Climbing Stairs | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Pet Care | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Driving | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Extended Computer Use | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Household Chores | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Lifting Children | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Reading/Concentration | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Bathing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Dressing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sleep | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Static Sitting | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Static Standing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Yard work | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Walking | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sweeping/Vacuuming | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Other: _____ | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |

Please mark **P** for in the **Past** or **C** for **Currently** have (if never leave blank)

| | | | | |
|---|---|---|---|---|
| ___ Headache | ___ Pregnant (Now) | ___ Dizziness | ___ Prostate Problems | ___ Ulcers |
| ___ Neck Pain | ___ Frequent Colds/Flu | ___ Loss of Balance | ___ Impotence/Sexual Dysfunction | ___ Heartburn |
| ___ Jaw Pain, TMJ | ___ Convulsions/Epilepsy | ___ Fainting | ___ Digestive Problems | ___ Heart Problem |
| ___ Shoulder Pain | ___ Tremors | ___ Double Vision | ___ Colon Trouble | ___ High Blood Pressure |
| ___ Upper Back Pain | ___ Chest Pain | ___ Blurred Vision | ___ Diarrhea/Constipation | ___ Low Blood Pressure |
| ___ Mid Back Pain | ___ Pain w/Cough/Sneeze | ___ Ringing in Ears | ___ Menopausal Problems | ___ Asthma |
| ___ Low Back Pain | ___ Foot or Knee Problems | ___ Hearing Loss | ___ Menstrual Problem | ___ Difficulty Breathing |
| ___ Hip Pain | ___ Sinus/Drainage Problem | ___ Depression | ___ PMS | ___ Lung Problems |
| ___ Back Curvature | ___ Swollen/Painful Joints | ___ Irritable | ___ Bed Wetting | ___ Kidney Trouble |
| ___ Scoliosis | ___ Skin Problems | ___ Mood Changes | ___ Learning Disabilty | ___ Gall Bladder Trouble |
| ___ Numb/Tingling arms, hands, fingers | | ___ ADD/ADHD | ___ Eating Disorder | ___ Liver Trouble |
| ___ Numb/Tingling legs, feet, toes | | ___ Allergies | ___ Trouble Sleeping | ___ Hepatitis (A,B,C) |

## List Any and All Prescription & Non-Prescription drugs you take:

_____
_____
_____
_____
_____
_____
_____

Patient's Name: _____

_____ _____/_____/_____

Patient or Authorized Person's Signature Date

_____ _____/_____/_____

Doctor's Signature Date Form Reviewed

# Informed Consent

**REGARDING:** Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Kimbrell Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Patient's Name: _____

_____ _____ /_____/_____

Patient or Authorized Person's Signature Date

# Kimbrell Chiropractic Notice of Privacy Practice

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation (**PHI**). In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

**PERMITTED DISCLOSURES:**

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

**YOUR RIGHTS:**

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

**COMPLAINTS:**

If you wish to make a formal complaint about how we handle your health information, please call Brittany at (251) 604-9006. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

## *Kimbrell Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….*

I have received a copy of Kimbrell Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____/_____/_____

Patient's Name DOB

_____ _____/_____/_____

Patient or Authorized Person's Signature Date

_____ _____/_____/_____

Witness Date