APPLICATION FOR CARE

Whom may we thank for referring you? ______________________________

PATIENT INFORMATION (Please Print)

Legal Name: ______________________ ❑ Male ❑ Female Date of Birth: _____ / _____ / _____

Address: ______________________ City/State: ______________ Zip: ________

Contact Phone #: ______________________ Email Address: ______________________

Alternate Contact #: ______________________ Marital Status: ❑ Single ❑ Married

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

Employer: ______________________ Occupation: ______________________

Spouse's Name: ______________________ Spouse's Employer: ______________________

Names of Children and Ages: ____

Emergency Contact Name/Relationship: ______________________ Phone: ______________

❑ I authorize this clinic to leave voice messages on all answering devices and to send text messages to capable devices.

❑ I authorize this clinic to send me emails for reminders and informational newsletters.

❑ I authorize this clinic to leave or give information to a spouse, emergency contact or any members of the household.

HISTORY OF COMPLAINT

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

Rate your pain for each complaint on a scale of **1** to **10** with **10** being the worst pain and zero being no pain (circle answer)

Primary/Chief complaint: ______________________ 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaint: ______________________ 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 ❑ mid-day ❑ PM ❑ late PM

How long does it last? ❑ It is constant ❑ I experience it on and off during the day ❑ It comes and goes throughout the week

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

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes If yes, how often: ______________________

Is this problem the result of ANY type of accident? ❑ No ❑ Yes If yes, please explain: ______________________

Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes If yes, whom? ______________________

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

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

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

What relieves your symptoms? ______________________

____

What makes them feel worse? ______________________

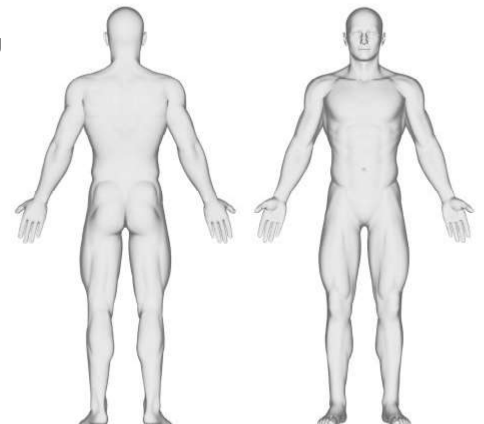
____

List Restricted Activity: ______________________

____

Usual Activity Level: ______________________

____



Adult Health History

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

Broken Bone ❑ Past ❑ Current ❑ Never Please Explain: ______

Dislocations ❑ Past ❑ Current ❑ Never Please Explain: ______

Fractures ❑ Past ❑ Current ❑ Never Please Explain: ______

Tumors ❑ Past ❑ Current ❑ Never Please Explain: ______

Arthritis ❑ Past ❑ Current ❑ Never Please Explain: ______

Cancer ❑ Past ❑ Current ❑ Never Please Explain: ______

Heart Attack ❑ Past ❑ Current ❑ Never Please Explain: ______

High Blood Pressure ❑ Past ❑ Current ❑ Never Please Explain: ______

Cerebral Vascular ❑ Past ❑ Current ❑ Never Please Explain: ______

Other Serious Condition ❑ Y ❑ N Please Explain: ______

Have you ever had any Major Injuries ❑ Past ❑ Current ❑ Never Please Explain: ______

______

Have you ever had any Major Surgeries ❑ Past ❑ Current ❑ Never Please Explain: ______

______

Have you tested with high triglycerides or high cholesterol? ❑ Y ❑ N Values? ______

Childhood Diseases ❑ Measles ❑ Mumps ❑ Chickenpox ❑ Other: ______

Adult Diseases ❑ Shingles ❑ Diabetes ❑ Other: ______

Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? ❑ Y ❑ N ______

Allergies to medication or food? ❑ Y ❑ N If yes, list reaction. ______

Specialists you are currently seeing: ______

Reason: ______

______

FAMILY HISTORY

Family history of heart disease? ❑ No ❑ Yes ❑ If yes, onset before age 50? ❑ Yes ❑ No

Any other hereditary conditions the doctor should be aware ❑ No ❑ Yes: ______

SOCIAL HISTORY

Smoker? ❑ Cigars ❑ Pipe ❑ Cigarettes How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

Alcoholic Beverage: consumption occurs ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

Recreational Drug use: consumption occurs ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

I hereby authorize payment to be made directly to Keen Family 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 Keen Family Chiropractic for any and all services I receive at this office.

Patient or Authorized Person's Signature ______ **Date Completed** _____ - _____ - _____

Doctor's Signature ______ **Date Form Reviewed** _____ - _____ - _____

Patient's Name ______ **File #** ______

Daily Activities

WHAT ARE THE EFFECTS OF YOUR CURRENT CONDITION(S) ON PERFORMANCE?

Please identify how your current condition would affect your ability to carry out activities that may routinely part of your life.

Activity				
Bending	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Concentrating	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Doing Computer Work	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Gardening	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Playing Sports	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Recreation Activities	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Shoveling	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sleeping	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Watching TV	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Carrying	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Dancing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Dressing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Lifting	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Pushing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Rolling Over	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sitting	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Standing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Working	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Climbing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Doing Household Chores	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Driving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Running	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sitting to Standing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Walking	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform

Patient's Name ______________________________ **File #** ____________________

Current Symptoms

Please mark **P** for in the past, **C** for Currently have and **N** for Never. Please mark an answer in every space.

___ Headache
___ Low Back Pain
___ Shoulder Pain
___ Pregnant (Now)
___ Ulcers
___ Impotence/Sexual Dysfunction
___ Convulsions/Epilepsy
___ Fainting
___ Colon Trouble
___ Chest Pain
___ Pain w/Cough/Sneeze
___ Asthma
___ Difficulty Breathing
___ PMS
___ Swollen/Painful Joints
___ Kidney Trouble
___ Learning Disability
___ ADD/ADHD
___ Liver Trouble

___ Migraines
___ Mid Back Pain
___ Foot or Knee Problems
___ Dizziness
___ Frequent Colds/Flu
___ Heartburn
___ Tremors
___ Digestive Problems
___ Hepatitis (A,B,C)
___ Blurred Vision
___ Ringing in Ears
___ Hearing Loss
___ Sinus/Drainage Problem
___ Lung Problems
___ Irritable
___ Scoliosis
___ Gall Bladder Trouble
___ Eating Disorder
___ Allergies

___ Neck Pain
___ Upper Back Pain
___ Hip Pain
___ Prostate Problems
___ Loss of Balance
___ Jaw Pain, TMJ
___ Double Vision
___ Heart Problem
___ Low Blood Pressure
___ Diarrhea/Constipation
___ Menopausal Problems
___ Menstrual Problem
___ Depression
___ Back Curvature
___ Bed Wetting
___ Skin Problems
___ Numb/Tingling arms, hands, fingers
___ Numb/Tingling legs, feet, toes
___ Trouble Sleeping

LIST PRESCRIPTION & NON-PRESCRIPTION DRUGS INCLUDING SUPPLEMENTS YOU TAKE:

____

____

____

____

____

____

Patient's Name ______________________________ **File #** ____________________

MAX NERVE SUPPLY

When was your most recent auto accident? ______________________________

What speed was the collision? ______________________________

Type of impact: ❑ Front Impact ❑ Side Impact ❑ Rear Impact

Was treatment received? Please describe ______________________________

When was your most recent strain at work? ______________________________

Please describe the manner of the injury______________________________

Was treatment received? Please describe ______________________________

Does your job require you remain in stressful postures? *(all day seating, repeated lifting, long term computer use)* ❑ Y ❑ N ________________

When was your most recent sports/recreation injury? *(football, wrestling, soccer, golf etc)* ______________________________

Trauma as a child? *(fall on your head, concussion, fall onto your back or tailbone, biking accident)* ❑ Y ❑ N ________________

MAX MIND

Do you average less than 7 hours of sleep per night? ❑ Y ❑ N

Do you ever take pills to go to sleep or relax? ❑ Y ❑ N

Do you often feel short on time and procrastinate on projects? ❑ Y ❑ N

Do you experience feelings of anxiety about completing tasks? ❑ Y ❑ N

Do you feel like you don’t give enough time or attention to important areas in your life like family, personal growth, or a hobby? ❑ Y ❑ N

Do you rely more on your memory than a planner and action list to get things done? ❑ Y ❑ N

Do you take time to pray, meditate, or visualize on a regular basis? ❑ Y ❑ N

MAX NUTRITION

Do you eat breakfast daily from Monday to Friday? ❑ Y ❑ N ______________________________

How many days per week do you skip one meal? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4+

How many fast food, refined foods, or pre-pared meals do you eat per week? ❑ 0 ❑ 1-3 ❑ 4-6 ❑ 7+

How many servings of fruit do you have on a given day? ❑ 0-1 ❑ 2-3 ❑ 4+

How many servings of vegetables do you have on a given day? ❑ 0-1 ❑ 2-3 ❑ 4-5

Do you regularly drink 1 or more per day any of the following? (circle all that apply) Diet Soda Coffee Juice Milk Soda

MAX OXYGEN AND LEAN MUSCLE

How many times per week do you exercise? ❑ 0-1 ❑ 2-3 ❑ 4+

Please circle which type of exercise you do most often: Cardiovascular Weight Training Low Impact (Yoga, Etc.)

What is your target weight?______________________ What is your current weight? ______________________

MINIMIZE TOXICITY

Are you regularly exposed to cleaning products or industrial chemicals? ❑ Y ❑ N

Have you ever noticed mold growing in your home or your place of work? ❑ Y ❑ N

Does your home, work, school, or car have damp or mildew smell? ❑ Y ❑ N

Have you received a full standard profile of vaccinations? ❑ Y ❑ N

Do you receive yearly flu shots? ❑ Y ❑ N How many flu shots have you received? (estimate)______________________

Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? ❑ Y ❑ N

Doctor’s Signature ______________________________ **Date Form Reviewed** _____ - _____ - _____

Patient’s Name ______________________________ **File #** ______________________________

Our Office Policies

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care,*** please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

PATIENT PRIVACY – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

YOUR CARE - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Keen Family Chiropractic is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctor uses a myriad of techniques to accomplish this goal. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

FIRST THINGS FIRST- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

PATIENT'S REPORT OF FINDINGS – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

Note: Patient retains the above Notice of Office Policies and Keen Family Chiropractic retains the signature sheet.

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. 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 another copy of this notice one will be provided to you. Once you have read this notice, please sign and return only the signature page 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 up coming 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 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 a digital copy of them we would be happy to provide this on a cd for you at no cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Kelsie Keen at (512) 335-8700. If she/he 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

Note: Patient retains the above Notice of Privacy Practice and Keen Family Chiropractic retains the signature sheet.

Office Policies and Notice of Privacy Practice Signature Sheet

Patient retains the Office Policies and Notice of Privacy Practice and Keen Family Chiropractic retains this signature sheet.

OFFICE POLICIES

I hereby acknowledge receiving a copy of the practices ‘Office Policies’ document, which I have read and retained. This page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this ‘Notice’. I further acknowledge that any concerns regarding these ‘Policies’ as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

Patient or Authorized Person’s Signature ____ **Date Completed** _____ - _____ - _____

Patient’s Name ____ **File #** ____

Witness Signature ____ **Date Form Reviewed** _____ - _____ - _____

NOTICE OF PRIVACY PRACTICE

I have received a copy of Keen Family 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 an time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that 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 or Authorized Person’s Signature ____ **Date Completed** _____ - _____ - _____

Patient’s Name ____ **File #** ____

Witness Signature ____ **Date Form Reviewed** _____ - _____ - _____

Informed Consent Regarding X-rays/Imaging Studies

MALES ONLY

By my signature below I have conveyed my understanding of the risks associated with exposure to x-rays and after careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient or Authorized Person's Signature ____ **Date Completed** _____ - _____ - _____

Patient's Name ____ **File #** ____

Witness Signature ____ **Date Form Reviewed** _____ - _____ - _____

FEMALES ONLY

The first day of my last menstrual cycle was on ______-______-______ (Date)

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient or Authorized Person's Signature ____ **Date Completed** _____ - _____ - _____

Patient's Name ____ **File #** ____

Witness Signature ____ **Date Form Reviewed** _____ - _____ - _____