Kingswood Parke Family Chiropractic
15508 W. Bell Rd. Ste 105
Surprise, AZ 85374

PATIENT HISTORY

(Please Print)

Patient's Name _____ Date _____

Phone (HM) _____ (WK) _____ (CELL) _____

Address _____ City, State, Zip _____

Birth Date _____ Age _____ Social Security # _____

Marital Status _____ # of Children _____ Email _____

Employer _____ Occupation _____

Spouse (Parent) Name _____ Spouse's Soc. Sec. # _____

How were you referred to our office? _____

Do you have any type of health insurance? ____ Company _____

Is this injury/illness related to an automobile accident? _____ Work related? _____

HIPAA

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The patient is also provided the right to request confidential communications or that a communication be made by alternative means.

Please check the boxes to indicate where we can leave a message:

□ Home Telephone □ Work Telephone □ Cell Phone
□ Written Communication (mail, email, fax, etc.)

I authorize this office to speak, fax and/or mail information pertaining to my case.

□ Insurance Company _____

□ Attorney _____ Phone _____

□ Family Members

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I have read and understand the HIPAA privacy notices shown to me. My signature acknowledges that I accept the terms of these notices, give authorization to be contacted, and give information about my treatment to the persons listed above.

Signature _____ Date _____

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List your chief complaints, in order of severity and duration of time:

1. _____
2. _____
3. _____

List other doctors consulted for the above condition(s):

1. _____
2. _____

Musculoskeletal System

- □ Low Back Pain
- □ Pain Between Shoulders
- □ Mumps
- □ Neck Pain
- □ Joint Pain/Stiffness
- □ Leg Pain/Difficulty Walking
- □ Difficulty Chewing/Clicking Jaw

Nervous System

- □ Nervousness
- □ Numbness
- □ Paralysis
- □ Dizziness
- □ Forgetfulness
- □ Confusion
- □ Depression
- □ Fainting
- □ Convulsions
- □ Stress

Male/Femail Issues

- □ Prostate/Sexual Dysfunction
- □ Menstrual Irregularity
- □ Menstrual Cramps

Gastrointestinal System

- □ Poor/Excessive Appetite
- □ Excessive Thirst
- □ Nausea/Vomiting
- □ Constipation
- □ Liver/Gall Bladder Problems
- □ Underweight/Overweight
- □ Abdominal Cramps/Bloating
- □ Heartburn
- □ Black/Bloody Stools
- □ Colitis

Genitourinary System

- □ Bladder Control Problems
- □ Painful/Excessive Urination
- □ Discolored/Bloody Urine

Cardiovascular System

- □ Chest Pain/Shortness of Breath
- □ Blood Pressure Problems
- □ Irregular Heartbeat
- □ Other Heart Problems
- □ Lung/Breathing Problems
- □ Varicose Veins
- □ Swollen Ankles
- □ Stroke

General Symptoms

- □ Vision Problems
- □ Hearing Difficulty
- □ Ear Aches/Infections
- □ Sore Throat
- □ Nasal Congestion
- □ Fatigue/Sleep Disturbances
- □ Fever
- □ Headaches

OFFICE NOTES ONLY

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PAYMENT AGREEMENT

I understand and agree that all services rendered to me are my responsibility and that I am personally responsible for payment on the date of service. I agree that my health insurance policies are an arrangement between my insurance carrier and myself. Kingswood Parke Family Chiropractic would be happy to assist me with the billing process, but I understand that I am ultimately responsible for any unpaid balances and that any amount authorized by my insurance company be paid directly to Kingswood Parke Family Chiropractic office.

Patient (Responsible Party) Signature _____ Date _____

FOR WOMEN ONLY: VERIFICATION OF NON-PREGNANCY

By my signature on this form, I, _____, do hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected at this particular time.

Name _____ Signature _____ Date _____

CHIROPRACTIC INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me by the doctor of chiropractic in this clinic. I understand I will have an opportunity to discuss with the doctor or personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient (Responsible Party) Signature _____ Date _____

Notice: Not all patients require X-rays to determine or verify a diagnosis, type and length of care. If your examination warrants X-ray analysis, the following office policy prevails:

1. All first visit charges are payable when services are rendered.
2. The fee paid for X-rays is for analysis only. The film itself is the property of this office and cannot be released.