Kenny Family Chiropractic
Registration and History

Personal and Family Health History

Name ______________________________

Date ______________________________

Address ______________________________

City ______________ State ____ Zip ____________

Phone: (H) ______________________________

(Cell) ______________________________

E-mail ______________________________

Date of Birth ______________________ Age ________

Sex ☐ Male ☐ Female

If Female, are you currently pregnant? Yes No

Family Doctor ______________________________

Referred By ______________________________

Occupation ______________________________

Employer ______________________________

Marital Status S M D W

Spouse's Name ______________________________

Spouse's Occupation ______________________________

<u>In case of Emergency, Contact</u>

Name ______________________________

Relationship ______________________________

Phone: (W) ______________________________

(Cell) ______________________________

Number of Children, Ages, and Previous Chiropractic Care?

Name ______________________________ Age ________ Yes___ No____ Reason ______________

Name ______________________________ Age ________ Yes___ No____ Reason ______________

Name ______________________________ Age ________ Yes___ No____ Reason ______________

Name ______________________________ Age ________ Yes___ No____ Reason ______________

Name ______________________________ Age ________ Yes___ No____ Reason ______________

Insurance:

Who is responsible for this account? ______________

Relationship to Patient______________________

Insurance Company ______________________

Group # ____________ ID # ______________

Is patient covered by additional Insurance: Y N

Subscriber's Name ______________________

Birth date ______________________

Relationship to Patient ______________________

Insurance Company ______________________

Group # ____________ ID # ______________

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with ____________________ and assign directly to Dr. ____________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ______________________

Signature of Patient, Parent, Guardian or Personal Representative Date

____ ______________________

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Current Health Habits

Exercise
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Habits
- ☐ Smoking — Packs/day ________
- ☐ Alcohol — Drinks/Week ________
- ☐ Coffee/ Caffeine Drinks — Cups/Day ________
- ☐ High Stress Level — Reason ________

Injuries/Surgeries you have had	Date
Falls ____________	______
____________	______
Head Injures ____________	______
____________	______
Broken Bones ____________	______
____________	______
Dislocation ____________	______
____________	______
Surgeries ____________	______
____________	______
____________	______

Current Health Condition

1. Present Complaint (be brief) Reason For Your Visit Today ____________

Pain or Problem started on ____________

Pains are: (select all that apply)

☐ Sharp ☐ Dull/Ache ☐ Burning
☐ Constant ☐ Intermittent ☐ Occasional
☐ Daily ☐ ___ times per Week/Month

What activities aggravate your condition/pain? ____________

What activities lessen your condition/pain? ____________

Is condition worse during certain times of the day? ____________

Does this condition interfering with your
☐ Sleep ☐ Routine ☐ Work
☐ Recreation ☐ Other ____________

Is this condition:
☐ getting progressively worse ☐ staying the same
☐ getting better ☐ Not sure

Other Doctors seen for this condition ____________

Any home remedies? ____________

2. Second Complaint (be brief) Reason For Your Visit Today ____________

Pain or Problem started on ____________

Pains are:

☐ Sharp ☐ Dull/Ache ☐ Burning
☐ Constant ☐ Intermittent ☐ Occasional
☐ Daily ☐ ___ times per Week/Month

What activities aggravate your condition/pain? ____________

What activities lessen your condition/pain? ____________

Is condition worse during certain times of the day? ____________

Does this condition interfering with your
☐ Sleep ☐ Routine ☐ Work
☐ Recreation ☐ Other ____________

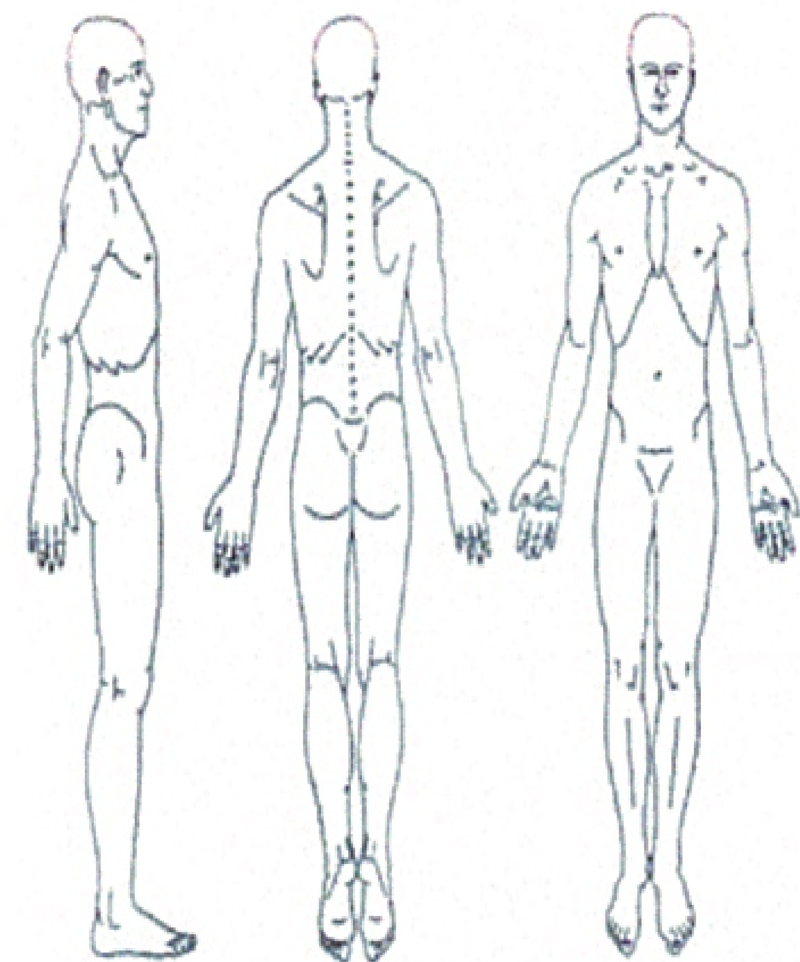
Is this condition:
☐ getting progressively worse ☐ staying the same
☐ getting better ☐ Not sure

Other Doctors seen for this condition ____________

Any home remedies? ____________

Other symptoms:

- ☐ Headaches
- ☐ Neck Pain
- ☐ Sleeping Problems
- ☐ Back Pain
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Chest Pains
- ☐ Dizziness
- ☐ Face Flushed
- ☐ Neck Stiff
- ☐ Pins & Needles in Legs
- ☐ Pins & Needles in Arms
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Shortness of Breath
- ☐ Fatigue
- ☐ Depression
- ☐ Light Bothers Eyes
- ☐ Loss of Memory
- ☐ Ears Ring
- ☐ Fever
- ☐ Fainting
- ☐ Cold Sweats
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Diarrhea
- ☐ Feet Cold
- ☐ Hands Cold
- ☐ Stomach Upset
- ☐ Constipation
- ☐ Loss of Balance
- ☐ Buzzing in Ear



Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other	
Father's Side	☐	☐	☐	☐	☐	____________
Mother's Side	☐	☐	☐	☐	☐	____________

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both doctor and patient to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: an adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A sate of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than the vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it; nor do we offer advice regarding treatment prescribed by others. Therefore, you understand that seeking advice from another type of health care provider should not interfere with the vertebral subluxation corrective care provided by this office.

OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation

I,________________________ have read and fully understand the above statements.
PRINT NAME

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

X________________________ X________________________
SIGNATURE **DATE**

PREGNANCY RELEASE

This is to certify, to the best of my knowledge, that I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been evaluation. I have been advised that x-ray can be hazardous to an unborn child.

X________________________ X________________________
SIGNATURE **DATE OF LAST MENSTRUAL(CYCLE)**

CONSENT TO EVALUATE AND ADJUST A MINOR CHIRD

I, ________________________ being the parent or legal guardian of __________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

X________________________ X________________________
SIGNATURE DATE

Kenny Family Chiropractic

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

________________________ ________________________ ____________

Printed Name **Signature** **Date**

Kenny Family Chiropractic & Injury Center

3418 Sonoma Blvd
Vallejo, Ca. 94590
707-552-2252

HIPAA Patient Consent Form

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing the consent. The terms of the notice may change. You can contact our office for an updated copy.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree with these restrictions.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent.

______________________________ ____/____/____

Signature Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO: ______________________________

ADDRESS: ______________________________

I, ______________________________ request the following information:

☐ X-rays ☐ History ☐ Records ☐ Diagnosis ☐ Treatment ☐ Reports ☐ Billings

concerning my: ☐ Accident ☐ Injury ☐ Illness ☐ Other ____________

To be released to:

Kenny Family Chiropractic
3418 Sonoma Blvd.
Vallejo, CA 94590
ph# (707) 552-2252 fax# (707) 552-2268

For the purpose of: ______________________________

According to Section 123.110 of The California Health & Safety Code, these records/films must be provided within 15 days of your receipt of this notice.

Signed: ______________________________ Date: ____________

☐ Patient ☐ Spouse ☐ Parent ☐ Guardian

A110