DISCOVER CHIROPRACTIC

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details
All information you supply is confidential. We comply with all federal privacy standards.

Discover Chiropractic
Dr. Christopher Kawa
136 Drum Point Road, Suite 2
Brick, NJ 08723
732-920-8844
www.discoverchironj.com

Today's Date

Your Last Name | Gender: ○ Male ○ Female

Your First Name | Your Middle Initial | Social Security Number

Address | Birthdate (MM/DD/YYYY

City | State | Zip | Marital Status | Children? ○ Yes ○ No

Email Address | Home Phone

Emergency Contact | Cell Phone

Your Occupation | Spouses Name

Your Employer | May we contact you at work? ○ Yes ○ No

Address | Preferred method of contact

City | State | Zip | Work Phone

Insurance Carrier | Primary Care Provider's Name

Insured's Last Name | Who Carries Policy? ○ Self ○ Spouse ○ Parent

First Name | Middle Initial | Insured's DOB (MM/DD/YYYY) | Policy Number

Insured's Employer

Address

City | State | Zip Code

To whom may we thank for referring you?

Have you consulted a chiropractor before? ○ No ○ Yes If so, when?_____

1. Did a particular symptom(s) prompt your visit? ○ Yes ○ No If yes, Explain: _____

_____

2. Are your symptoms the result of any of the following? (darken circle)

○ An Accident or injury ○ Work ○ Auto ○ Other: _____

○ A worsening long-term problem

○ An interest in: ○ Wellness ○ Other: _____

3. Onset (when did you first notice your current symptoms?) _____

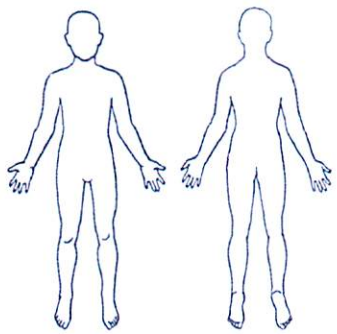
4. Intensity (how extreme are your current symptoms?) Absent -○-○-○-○-○-○-○-○-○- Agonizing

5. Duration and timing ○ Constant ○ Comes and goes How often? _____

6. Quality of symptoms (what does it feel like?) (darken cirlcle)

- ○ Numbness
- ○ Tingling
- ○ Stiffness
- ○ Dull
- ○ Aching
- ○ Cramps
- ○ Nagging
- ○ Sharp
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Stabbing
- ○ Other

7. Location (where does it hurt?) Circle the areas on the illustration "O" for current condition - "X" for condition experienced in the past



8. Radiation Does it affect other areas of your body? To what area does the pain radiate, shoot or travel?

_____

_____

9. Aggravating or relieving factors (what makes it better or worse, such as time of day, movements certain activities etc.,?)

Worsen pain: _____

_____

Lessen pain: _____

_____

10. Prior Intervention (what have you done to relieve the symptoms?)

- ○ Prescription medications
- ○ Over-the-counter drugs
- ○ Homeopathic remedies
- ○ Physical therapy
- ○ Surgery
- ○ Acupuncture
- ○ Chiropractic
- ○ Massage
- ○ Ice
- ○ Heat
- ○ Other: _____

11. What else should Dr. Kawa know about your current condition?

_____

_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household activities: _____

Personal relationships: _____

13. Check the illnesses you have <u>had</u> in the past or <u>have</u> now.

- ○ AIDS
- ○ Alcoholism
- ○ Allergies
- ○ Arteriosclerosis
- ○ Cancer
- ○ Chicken Pox
- ○ Diabetes
- ○ Glaucoma
- ○ Goiter
- ○ Heart Disease
- ○ Hepatitis
- ○ HIV Positive
- ○ Malaria
- ○ Measles
- ○ Multiple Sclerosis
- ○ Mumps
- ○ Polio
- ○ Rheumatic Fever
- ○ Scarlet Fever
- ○ Sexually Transmitted Disease
- ○ Stroke
- ○ Tuberculosis
- ○ Typhoid Fever
- ○ Ulcer
- ○ Other: _____

14. Injuries: Have you ever . . .

- ○ Had a fractured or broken bone
- ○ Had spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Broken ribs
- ○ Had major falls

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15. Operations: Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine: _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

_____

16. Treatments: Check the ones you've received in the past or are receiving currently.

Past	Present	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements: _____

_____

17. Medications (prescription and over-the-counter): _____

_____

_____

18. Activites of Daily Living - How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate	Severe Effect
Sitting	○	○	○	○
Rising out of a chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of a car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

19. What is the major stressor in your life? _____

20. How many hours of sleep do you average per night? _____

21. What is the type and approximate age of your mattress and pillow? _____

22. What is your preferred sleeping position? _____

23. Describe your typical eating habits: ○ skip breakfast ○ two meals per day ○ three meals per day ○ snacking between meals

24. What would be the most significant thing that you could do to improve your health?

_____

25. In addition to the main reason for your visit today, what additional health goals do you have?

_____

_____

_____

_____

_____

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Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

_____ Initials **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art form from medicine and does not proclaim to cure any named disease or entity.**

_____ Initials **I may request a copy of the Privacy Policy and understand it described how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

_____ Initials **I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. date of last menstrual perdiod (MM/DD/YYYY):**

_____ Initials **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional card, letter, emails or health information to me as an extension of my care in this office.**

_____ Initials **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

_____ Initials **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.**

If the patient is a minor child, print child's full name:_____

_____ Signature

_____ Date (MM/DD/YYYY)

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_____

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Discover Chiropractic

Dr. Christopher Kawa

Consent to Initiate Care

At our office, we have one simple goal. We want to render the highest quality Chiropractic care at the lowest possible fee. In order to accomplish this goal, we have altered some business procedures in this clinic to keep our fees reduced. Please read over these procedures below to understand how our clinic functions, and to decide if you wish to participate. If you have any questions please direct them to the receptionist.

1. Patients may choose to be cared for by any available staff doctors present on any given visit.
2. You may choose to submit receipts to your insurance company or other third-party health care programs, but payment for such services by insurance companies is neither implied nor agreed to by our office. Our Office takes *no responsibility* for non-payment by insurance companies for services rendered at our clinic.
3. _____(practice name) will not respond to *any* requests for paperwork for insurance purposes or even acknowledge insurance requests for information on any patient's case. However, patients may have a copy of their records and the original x-rays at any time they request.
4. No balances can be kept or run by patients at any time.
5. All adjustment visits are paid immediately ***prior*** to the service being rendered.
6. All examinations and x-rays are paid upon completion of these services.
7. Our clinic reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served.

To initiate care at our facility, there are two required visits you will be scheduled for. If you cannot attend either of these two visits, the negative impact on your care will be profound, and we cannot in good conscious initiate your care. These required visits are:

1. **Initial Interview and Examination:** *This visit will consist of a health history, chiropractic examination, and x-rays if needed. (This is probably the visit you are present for now) Total time about 30 – 45 minutes.*
2. **Report of Findings:** *This visit will consist of a detailed report of findings with recommendations for your care. Also included is information on chiropractic health and wellness. Recommendations on what to do between visits and a detailed explanation of your care plan. X-rays will also be reviewed at this time. We recommend that spouses and adult family members attend this visit with the patient. Children should not attend this visit as the material may be too advanced and children will find it difficult to stay attentive without becoming a distraction for that amount of time. Due to the time required, there are only certain times this visit is given. Check with our receptionist or one of our doctors for available times. Total visit time about 60 -75 minutes.*

I wish to initiate care at _____(practice name). I have read and understand the Consent to Initiate Care and agree to all terms. I understand that I am under no obligation to receive or continue care.

Print your name _____ **Today's Date** _____

Sign your name _____