Welcome

And thank you for choosing Kastner Family Chiropractic

Patient Information

Today's Date:_____

Name: _____

Prefer to be called: _____ ☐ Male ☐ Female

Address:_____

City_____State_____Zip_____

SS#: _____ DL#: _____

Birthdate: _____ Age: _____ # Children: _____

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Employer: _____

Employer Address: _____

_____

Spouse's/Partner's Name:_____

Birthdate: _____ SS#:_____

Spouse's Employer:_____

How did you hear about us?: _____

Insurance Information

Insurance Co.:_____

Policy/Group #:_____

ID/Claim #:_____

Name on Insurance Policy:_____

Relationship to Patient:_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Assignment and Release

I certify that I (or my dependent) have insurance coverage with _____ and assign all insurance benefits directly to Kastner Family Chiropractic. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I understand that my insurance policy is an arrangement between the insurance carrier and myself, and I am financially responsible for all charges whether paid by the insurance company or not. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

Contact Information

Home Phone:_____ Cell:_____ Work Phone: _____ Extension:_____

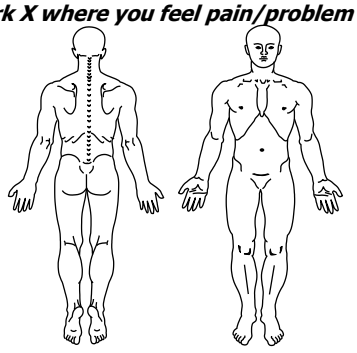
Email Address: _____ May we confirm appointments by email? ☐ Yes ☐ No

In case of emergency contact:

Name:_____ Relationship:_____ Home Phone:_____ Work:_____

Patient Condition

Mark X where you feel pain/problem



Your Present Complaint:_____

When did your condition begin?_____

Is condition due to an accident? ☐ No ☐ Yes, Auto ☐ Yes, Work ☐ Yes, Other

If so, what was the date of the accident? _____

When is your pain at its worst?_____

How often do you have this pain?_____% of the time.

Health History

Other health professional seen for your condition (please list):

Chiropractor _____ Results: _____

Medical Doctor _____ Results: _____

Other _____ Results: _____

Date of Last: Physical Exam _____ Spinal Exam _____ Spinal X-Ray _____

Blood Test _____ Urine Test _____ MRI/CT Scan _____

Place an X to indicate if you have had any of the following:

- ☐ AIDS/HIV
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Backache
- ☐ Cancer
- ☐ Cold Hands/Feet
- ☐ Concussion
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fractures
- ☐ Gout
- ☐ Headache
- ☐ Heartburn
- ☐ Heart Disease
- ☐ Hernia
- ☐ Herniated Disk
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Muscular Dystrophy
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Numbness
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pinched Nerve
- ☐ Pins and Needles
- ☐ Polio
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Ringing in Ears
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Suicide Attempt
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Ulcers
- ☐ Vaccine Reaction
- ☐ Vaginal Infections

Women Only:

Are you pregnant? ☐ Yes Due Date _____ ☐ No Date of last menstrual cycle _____

Activities

Exercise	Work	Habits
☐ Daily	☐ Sitting	☐ Smoke _____/day
☐ Frequently	☐ Standing	☐ Alcohol _____/week
☐ Periodically	☐ Light Labor	☐ Caffeine _____/day
☐ None	☐ Heavy Labor	☐ High Stress Level

Injuries/Surgeries

Falls: _____

Head Injuries: _____

Dislocations: _____

Surgeries: _____

Broken Bones: _____

Serious Illness\Injury: _____

Medications

Please list any medications you take: _____

_____

Please list any supplements/herbs you take: _____

I understand the information in this form and guarantee it was completed correctly to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes in my address, insurance, or medical status.

Patient Signature _____ Date _____

Patient Name: _____

Activities of Daily Living Assessment

Rate your current difficulties by placing the appropriate number in the space. If any activity does NOT cause pain or if pain does not effect an activity, leave space blank.

1 This activity causes some pain, but is only a minor annoyance
2 This activity causes a significant amount of pain, but I can do it.
3 I cannot perform this activity due to pain and disability.

Self Care and Personal Hygiene

___ bathing/showering
___ grooming hair
___ washing face
___ brushing teeth
___ making the bed
___ putting on shirt
___ putting on shoes
___ putting on pants
___ cooking
___ eating
___ washing dishes
___ taking out trash
___ doing laundry
___ using the restroom

Physical Activities

___ standing
___ sitting
___ reclining
___ walking
___ squatting
___ kneeling
___ reaching
___ bending forward
___ bending back
___ bending right
___ bending left
___ looking left
___ looking right
___ twisting left
___ twisting right

Functional Activity

___ carrying small objects
___ carrying large objects
___ carrying briefcase/purse
___ lifting object off floor
___ lifting weights
___ climbing stairs/incline
___ pushing/pulling while seated
___ pushing/pulling while standing
___ exercising upper body
___ exercising lower body

Social and Recreational Activities

___ bowling
___ biking
___ walking
___ jogging
___ hunting/fishing
___ horse riding
___ swimming
___ competitive sports
___ gardening
___ golfing
___ dancing
___ _____

Difficulties with Travel

___ driving in car
___ riding as passenger
___ driving for long periods of time
___ riding as passenger for long periods of time

Other Activities

Use this scale for the following activities:

1 This activity is slightly affected by my condition.
2 This activity is moderately affected by my condition.
3 This activity is severely affected by my condition.
4 I cannot perform this activity due to my condition.

___ concentrating
___ writing
___ listening
___ using computer
___ reading
___ sleeping
___ studying
___ sexual relations

Kastner Family Chiropractic
Dr. Brenda K. Kastner

Notice of Privacy Practices – Acknowledgement

We keep a record of the health care services we provide you. You may ask to see a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so in writing, or unless the law authorizes or compels us to do so. You ma see y record or get more information about it by contacting Dr. Brenda Kastner, DC.

Our Notice of Privacy Practices describes more in detail how your health information may be used and disclosed. It additionally describes how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Signature of patient or legal guardian Date

_____ _____
Printed Name Relationship (parent, guardian, personal representative, etc.)

This form shall be retained in your health record.