BAKER FAMILY CHIROPRACTIC PSC

1060 Chinoe Rd. Ste. 124 Lexington, KY 40502 859-335-9355

PATIENT APPLICATION FORM

Name_____Date_____

Address_____

_____

City State Zip

Sex M F Birthdate___/___/___

Height_____ Weight_____

Marital Status M S W D

Occupation_____

Employer_____

Spouses Name_____

Spouses Occupation_____

Who may we thank for referring you?_____

_____

C-phone_____W/Hphone_____

e-mail_____

emergency contact_____

Phone #_____

Insurance Company_____

Do you have Medicare Y N

Do you have Medicaid Y N

ACCIDENT INFORMATION

Is this due to an accident? Y N

Type Auto Work Home Other_____

Have you made a report Y N

To Whom_____

PATIENT CONDITION

Reason for visit_____

When did your symptoms appear?_____

Is this condition getting progressively worse? Y N

Mark the location of your symptoms on the diagram.

Rate the severity of your symptoms from 1 (least) to 10 (severe) pain__

Type of pain: Sharp Dull Throbbing Numb Aching Shooting

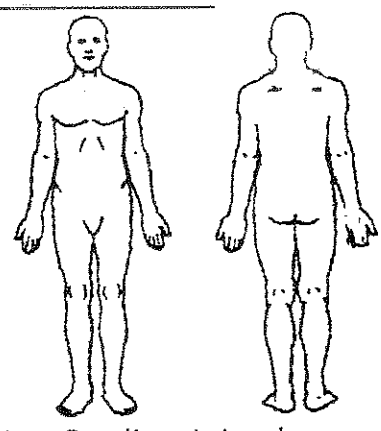
Burning Tingling Cramps Stiffness Swelling Other

How often do you have the symptoms?_____

Is it constant or does it come and go?_____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are difficult to perform Sitting Standing Walking Bending Lying down.



I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, andy fee for professional services rendered me will be immediately due and payable.

Patient's Signature_____Date___/___/_____

Or Guardian Signature_____Date___/___/_____

HEALTH HISTORY

Please mark the appropriate column (C = Current, P = Past) to indicate if you have had any of the following:

C	P	General
☐	☐	Allergy
☐	☐	Chills
☐	☐	Convulsions
☐	☐	Depression
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Headache
☐	☐	Loss of Sleep
☐	☐	Loss of Weight
☐	☐	Nervousness
☐	☐	Tremors
		G-I
☐	☐	Belching / Gas
☐	☐	Colon Trouble
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Difficult Digestion
☐	☐	Gall Bladder Trouble
☐	☐	Hemorrhoids
☐	☐	Jaundice
☐	☐	Liver Trouble
☐	☐	Nausea
☐	☐	Pain Over Stomach
☐	☐	Ulcers

C	P	Muscle / Joint
☐	☐	Arthritis
☐	☐	Bursitis
☐	☐	Hernia
☐	☐	Low Back Pain
☐	☐	Neck Pain / Stiffness
		Pain or Numbness:
☐	☐	Between Shoulders
☐	☐	Shoulders
☐	☐	Arms
☐	☐	Elbows
☐	☐	Hands
☐	☐	Hips
☐	☐	Legs
☐	☐	Knees
☐	☐	Feet
☐	☐	Painful Tailbone
☐	☐	Sciatica
☐	☐	Swollen Joints
		Respiratory
☐	☐	Chest Pain
☐	☐	Chronic Cough
☐	☐	Difficult Breathing
☐	☐	Coughing up Blood
☐	☐	Spitting up Phlegm
☐	☐	Wheezing

C	P	E.E.N.T.
☐	☐	Colds
☐	☐	Crossed Eyes
☐	☐	Deafness
☐	☐	Earache
☐	☐	Ear Noises
☐	☐	Enlarged Glands
☐	☐	Eye Flashes
☐	☐	Eye Pain
☐	☐	Hay Fever
☐	☐	Hoarseness
☐	☐	Nasal Obstruction
☐	☐	Nosebleeds
☐	☐	Sinus Infection
☐	☐	Sore Throat
		Genito-Urinary
☐	☐	Bed Wetting
☐	☐	Blood in Urine
☐	☐	Frequent Urination
☐	☐	Can't Control Urine
☐	☐	Painful Urination
☐	☐	Prostrate Trouble
☐	☐	Puss in Urine

C	P	Cardiovascular
☐	☐	Hardening Arteries
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Pain Over Heart
☐	☐	Cold Hands or Feet
☐	☐	Rapid Heart Beat
☐	☐	Slow Beating Heart
☐	☐	Swelling Ankles
☐	☐	Varicose Veins
		Skin
☐	☐	Bruise Easily
☐	☐	Dryness
☐	☐	Hives or Allergy
☐	☐	Itching
☐	☐	Skin Lesions (Rash)
		Women Only
☐	☐	Cramps / Backache
☐	☐	Excessive Flow
☐	☐	Hot Flashes
☐	☐	Irregular Cycle
☐	☐	Lumps in Breast
☐	☐	Menopausal Symptoms
☐	☐	Painful Period
☐	☐	Vaginal Discharge
☐	☐	Miscarriage

List all medically diagnosed conditions: _____

List all injuries and dates: (including falls, broken bones, dislocations, etc.): _____

_____

List all surgeries and dates, including outpatient: _____

_____

Medications and Purpose	Allergies	Vitamins / Herbs / Minerals

Exercise	Work Activity	Habits		Women Only
☐ None	☐ Sitting	☐ Smoking	Packs / Day _____	
☐ Moderate	☐ Standing	☐ Alcohol	Drinks / Week _____	Last Period _____
☐ Daily	☐ Light Labor	☐ Coffee / Caffeine	Cups / Day _____	Are you pregnant? Y N
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason _____	Due Date _____

Your signature below will verify that all information you have given is accurate and complete.

Name: _____ Date ____ / ____ / ____

FAMILY HEALTH HISTORY

Many health problems are hereditary in nature and may be handed down generation after generation.

Patient: _____

Please review the below-listed diseases and conditions and indicate these that are current health problems of a family member. Leave blank those spaces that do not apply, If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age( )	MOTHER Age( )	SPOUSE Age( )	BROTHER(S) Age( )	Age( )	SISTER(S) Age( )	Age( )	CHILDREN Age( )	Age( )	Age( )
Arthritis										
Asthma-Hay Fever										
Back Trouble										
Bursitis										
Cancer										
Constipation										
Diabetes										
Disc Problem										
Emphysema										
Epilepsy										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Nervousness										
Neuritis										
Neuralgia										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										

If any of the above family members are deceased, please list their age at death and cause: _____

_____

_____

Patient Specific Functional Scale

Patient: _____ Date: ____/____/____

Please identify and circle important activities that you are unable to do, or have difficulty doing as a result of the problem(s) you are being treated for at this office. Please use these **examples** as a starting point to remind you, but be very **specific** in your response. For example, if housework bothers you, be specific and name the exact part of housework that is difficult, such as "vacuuming", or "cleaning the bathtub". *(Remember, you are not limited to this list, you may choose something else and write them in at the bottom of the list.)*

Examples:

Sitting (how long?) Bending Lifting Walking (how far?) Gardening (be specific) Standing in one place Driving Sleeping Putting on socks/shoes Reaching Pushing Pulling Moving in bed Standing up from sitting Stairs Getting out of bed Bathing Sexual activities	Reading Running Sports (be specific) Working (be specific) Carrying (be specific) Lying down Getting in/out of bed Childcare (be specific) Shopping (be specific) Cleaning (be specific) Housework (be specific - Vacuuming, Making beds, Mopping, Dusting, Laundry, etc.) Hobbies (be specific – chess, knitting, crosswords, computer) _____ _____ _____

Now choose the 3 most important to you and write them in the boxes below. Please score the difficulty of each activity on the adjacent scale, remembering that "0" indicates that you are totally unable to perform that activity, and "10" indicates that you are perfectly able to perform the activity as well as you could before your problem.

The three most important activities you are unable to do or have difficulty with as a result of these problem(s):	0 = Unable To Perform At All:										10 = Able to Perform as Well as Before Problem
1.	0	1	2	3	4	5	6	7	8	9	10
2.	0	1	2	3	4	5	6	7	8	9	10
3.	0	1	2	3	4	5	6	7	8	9	10

Please sign here: _____

ASSIGNMENT and RELEASE

I hereby instruct and direct my insurance company to pay by check made out and mailed to:

Baker Family Chiropractic P.S.C. 1060 Chinoe Rd. Suite 124 Lexington, KY 40502

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.
A photocopy of this Assignment shall be considered as effective and valid as the original.
I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
I authorize the taking of photographs and x-rays to be used for treatment purposes.
I authorize performance of other diagnostic and therapeutic procedures for treatment purposes.
I authorize the release of information to family physicians and employer.

Patients Signature:_____ Date:_____

Guardian Signature:_____ Date:_____

HIPPA CONSENT FORM

Consent for Purposes of Treatment, Privacy Acknowledgement, Payment and Healthcare Operations

I consent to the use of disclosure of my protected health information by **Baker Family Chiropractic** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Baker Family Chiropractic.** I understand that diagnosis or treatment of my by **Dr. Baker** may be conditioned upon my consent as evidenced by my signature on this document.
I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Baker Family Chiropractic** is not required to agree to the restrictions that I may request. However, if **Baker Family Chiropractic** agrees to a restriction that I request, the restriction is binding on **Baker Family Chiropractic** and **Dr. Baker**.
I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr. Baker** or **Baker Family Chiropractic** has taken action in reliance on this consent.
My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.
I understand I have a right to review **Baker Family Chiropractor's** Notice of Privacy Practices prior to signing this document. The **Baker Family Chiropractor's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Baker Family Chiropractic**. The Notice of Privacy Practices for **Baker Family Chiropractic** is also provided **at the front desk**. This Notice of Privacy Practices also describes my rights and the **Baker Family Chiropractic** duties with respect to my protected health information.
Baker Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Guardian Date Name of Patient or Guardian Relationship to Patient

- This is to acknowledge that I have been given a personal copy of this office's Notice of Privacy Practices.

Initial_____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, 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 on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. 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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____

Signature of Patient:_____

Name Printed of Guardian/Parental and Relationship to Patient:_____

Guardian/Parental Signature:_____

Date:_____

Doctor of Chiropractic Name:_____

Signature of Doctor of Chiropractic:_____

Date:_____