

Patient Contact Information

Today's Date _____

Last Name _____ First Name _____ Preferred to be called _____

Date of Birth _____

Gender Male/Female

Social Security Number: _____

Height _____"

Circle: Married/Single/Other

Circle: Employed/Full-time Student/Part-time Student/_____

Employer _____ Occupation _____

Language Circle: English/_____

Smoking status Current everyday smoker Current someday smoker Former smoker Never smoked

Frequency 1-5 cigarettes/day 6-10 cigarettes/day 1/2 pack/day 1 pack/day
(if current) 1 1/2 pack/day 2 pack/day 2 1/2 pack/day 3+ pack/day

Are you interested in quitting? Yes/No

Race (circle) Decline to disclose White American Indian or Alaska Native
 Asian Indian Black, African American Chinese Filipino
 Guamanian Japanese Korean Samoan
 Vietnamese Native Hawaiian, Other Pac. Islander
 Other Asian Other Race

Ethnicity (circle) Decline to disclose Not of Hispanic, Latino, or Spanish Origin
 Puerto Rican Another Hispanic, Latino, or Spanish
 Cuban Mexican, Mexican American, or Chicano

Address _____ City _____ State _____ Zip _____

Home (_____) _____ - _____ Work (_____) _____ - _____ Cell (_____) _____ - _____

Email _____

Insurance Information (if applicable)

Insurance Company _____

Relationship to patient: Self ____ Spouse ____ Parent ____ (please bring a copy of your insurance card)

Name of the Insured _____ Insured's Date of Birth _____

Insurance ID # _____ Group # _____

Plan Name _____

Phone # _____

Who may we thank for referring you? _____

Have you visited www.KutyChiropractic.com? Circle: Yes/No

Spouse's Name _____

Names and Ages of Children _____

Parents/Guardians (if patient is a minor) _____

Primary Doctor (PCP) _____ Phone # _____ May we contact your Doctor? Yes/No

Do you have any open liability or work compensation claims? Yes/No

Have you ever been to a Doctor of Chiropractic for treatment? Yes/No

When? _____ What was the focus of your treatment? _____

Name _____ Date of Birth _____ Date _____

Your Health

What health-related concerns prompted today's visit?

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Have you had any imaging or lab work related to these symptoms? Yes/No

If yes, where and when? _____

Symptom 1

- On a scale from 0-10, with 10 being the worst, please rate your symptom: 0 1 2 3 4 5 6 7 8 9 10
 - When awake, what percentage do you experience the above symptom: 10 20 30 40 50 60 70 80 90 100
 - When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
 - What makes the symptom worse? (check all that apply)

<input type="checkbox"/> Lying on back	<input type="checkbox"/> Getting in/out of car	<input type="checkbox"/> Housework	<input type="checkbox"/> Walking	<input type="checkbox"/> Standing
<input type="checkbox"/> Lying on side	<input type="checkbox"/> Gripping	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Squatting	<input type="checkbox"/> Sneezing
<input type="checkbox"/> Turning in bed	<input type="checkbox"/> Dressing self	<input type="checkbox"/> Pulling	<input type="checkbox"/> Bending forward	<input type="checkbox"/> Coughing
<input type="checkbox"/> Laying on stomach	<input type="checkbox"/> Kneeling	<input type="checkbox"/> Reaching	<input type="checkbox"/> Bending backward	<input type="checkbox"/> Reading
<input type="checkbox"/> Exercise	<input type="checkbox"/> Stretching	<input type="checkbox"/> Computer use	<input type="checkbox"/> Stress	<input type="checkbox"/> Sit to Stand
<input type="checkbox"/> Moving Neck	<input type="checkbox"/> Getting in/out of bed	<input type="checkbox"/> Moving Back	<input type="checkbox"/> Sitting	_____
 - What makes the symptom better? (circle all that apply): Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, chiropractic, nothing, Other _____
 - Describe the quality of the symptom (circle all that apply): Sharp, dull, achy, burning, throbbing, stabbing, deep, nagging, annoying, numb, tingling, stiff, swollen, Other _____
 - Does the symptom travel/radiate? (circle): yes no If yes, where? _____
 - Is it worse at certain times? (circle) Morning Afternoon Evening Night or Unaffected by time of day
- What are your goals related to this symptom? _____

Symptom 2

- On a scale from 0-10, with 10 being the worst, please rate your symptom: 0 1 2 3 4 5 6 7 8 9 10
- When awake, what percentage do you experience the above symptom: 10 20 30 40 50 60 70 80 90 100
- When did the symptom begin? _____
- Did the symptom begin suddenly or gradually? (circle one)
- How did the symptom begin? _____
- What makes the symptom worse? (check all that apply)

<input type="checkbox"/> Lying on back	<input type="checkbox"/> Getting in/out of car	<input type="checkbox"/> Housework	<input type="checkbox"/> Walking	<input type="checkbox"/> Standing
<input type="checkbox"/> Lying on side	<input type="checkbox"/> Gripping	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Squatting	<input type="checkbox"/> Sneezing
<input type="checkbox"/> Turning in bed	<input type="checkbox"/> Dressing self	<input type="checkbox"/> Pulling	<input type="checkbox"/> Bending forward	<input type="checkbox"/> Coughing
<input type="checkbox"/> Laying on stomach	<input type="checkbox"/> Kneeling	<input type="checkbox"/> Reaching	<input type="checkbox"/> Bending backward	<input type="checkbox"/> Reading
<input type="checkbox"/> Exercise	<input type="checkbox"/> Stretching	<input type="checkbox"/> Computer use	<input type="checkbox"/> Stress	<input type="checkbox"/> Sit to Stand
<input type="checkbox"/> Moving Neck	<input type="checkbox"/> Getting in/out of bed	<input type="checkbox"/> Moving Back	<input type="checkbox"/> Sitting	_____
- What makes the symptom better? (circle all that apply): Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, chiropractic, nothing, Other _____

Name _____ Date of Birth _____ Date _____

- Describe the quality of the symptom (circle all that apply): Sharp, dull, achy, burning, throbbing, stabbing, deep, nagging, annoying, numb, tingling, stiff, swollen, Other _____
 - Does the symptom travel/radiate? (circle): yes no If yes, where? _____
 - Is it worse at certain times? (circle) Morning Afternoon Evening Night or Unaffected by time of day
- What are your goals related to this symptom? _____
-

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please rate your symptom: 0 1 2 3 4 5 6 7 8 9 10
 - When awake, what percentage do you experience the above symptom: 10 20 30 40 50 60 70 80 90 100
 - When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
 - What makes the symptom worse? (check all that apply)

<input type="checkbox"/> Lying on back	<input type="checkbox"/> Getting in/out of car	<input type="checkbox"/> Housework	<input type="checkbox"/> Walking	<input type="checkbox"/> Standing
<input type="checkbox"/> Lying on side	<input type="checkbox"/> Gripping	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Squatting	<input type="checkbox"/> Sneezing
<input type="checkbox"/> Turning in bed	<input type="checkbox"/> Dressing self	<input type="checkbox"/> Pulling	<input type="checkbox"/> Bending forward	<input type="checkbox"/> Coughing
<input type="checkbox"/> Laying on stomach	<input type="checkbox"/> Kneeling	<input type="checkbox"/> Reaching	<input type="checkbox"/> Bending backward	<input type="checkbox"/> Reading
<input type="checkbox"/> Exercise	<input type="checkbox"/> Stretching	<input type="checkbox"/> Computer use	<input type="checkbox"/> Stress	<input type="checkbox"/> Sit to Stand
<input type="checkbox"/> Moving Neck	<input type="checkbox"/> Getting in/out of bed	<input type="checkbox"/> Moving Back	<input type="checkbox"/> Sitting	<input type="checkbox"/> _____
 - What makes the symptom better? (circle all that apply): Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, chiropractic, nothing, Other _____
 - Describe the quality of the symptom (circle all that apply): Sharp, dull, achy, burning, throbbing, stabbing, deep, nagging, annoying, numb, tingling, stiff, swollen, Other _____
 - Does the symptom travel/radiate? (circle): yes no If yes, where? _____
 - Is it worse at certain times? (circle) Morning Afternoon Evening Night or Unaffected by time of day
- What are your goals related to this symptom? _____
-

Symptom 4 _____

- On a scale from 0-10, with 10 being the worst, please rate your symptom: 0 1 2 3 4 5 6 7 8 9 10
 - When awake, what percentage do you experience the above symptom: 10 20 30 40 50 60 70 80 90 100
 - When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
 - What makes the symptom worse? (check all that apply)

<input type="checkbox"/> Lying on back	<input type="checkbox"/> Getting in/out of car	<input type="checkbox"/> Housework	<input type="checkbox"/> Walking	<input type="checkbox"/> Standing
<input type="checkbox"/> Lying on side	<input type="checkbox"/> Gripping	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Squatting	<input type="checkbox"/> Sneezing
<input type="checkbox"/> Turning in bed	<input type="checkbox"/> Dressing self	<input type="checkbox"/> Pulling	<input type="checkbox"/> Bending forward	<input type="checkbox"/> Coughing
<input type="checkbox"/> Laying on stomach	<input type="checkbox"/> Kneeling	<input type="checkbox"/> Reaching	<input type="checkbox"/> Bending backward	<input type="checkbox"/> Reading
<input type="checkbox"/> Exercise	<input type="checkbox"/> Stretching	<input type="checkbox"/> Computer use	<input type="checkbox"/> Stress	<input type="checkbox"/> Sit to Stand
<input type="checkbox"/> Moving Neck	<input type="checkbox"/> Getting in/out of bed	<input type="checkbox"/> Moving Back	<input type="checkbox"/> Sitting	<input type="checkbox"/> _____
 - What makes the symptom better? (circle all that apply): Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, chiropractic, nothing, Other _____
 - Describe the quality of the symptom (circle all that apply): Sharp, dull, achy, burning, throbbing, stabbing, deep, nagging, annoying, numb, tingling, stiff, swollen, Other _____
 - Does the symptom travel/radiate? (circle): yes no If yes, where? _____
 - Is it worse at certain times? (circle) Morning Afternoon Evening Night or Unaffected by time of day
- What are your goals related to this symptom? _____
-

Name _____ Date of Birth _____ Date _____

Medical History (check all that apply)

Birth Defect High blood pressure Weakness Swelling
 Cancer Obesity Headache _____
 High cholesterol Stroke Dizziness _____

Surgical History _____

Women Only

Month or year of your last: GYN/OB Exam? _____ Mammogram? _____
Menses: Regular Irregular Menopausal Post-menopausal Hysterectomy
Hormone Replacement Therapy? Current/Past/No
Are you pregnant? Yes/No _____ weeks Are you trying to get pregnant? Yes/No

Family History _____

Social History

Rate your quality of sleep (0 none – 10 best) _____ How many hours do you sleep on average? _____
Rate your energy level (0 none – 10 best) _____ What gives you energy? _____
Rate your stress level (0 none – 10 high) _____ What gives you stress? _____
How many ounces do you drink a day of: Water? _____ Soda? _____ Coffee? _____ Tea? _____
Alcohol use? Yes/No Type and Frequency? _____
Do you exercise? Yes/No What type of exercise do you do? How often? _____
Hobbies? _____
How would you describe your diet? Healthy _____ So-so _____ Not good _____ Poor _____
Are you interested in nutritional counseling? Yes/No
Current weight? _____ Highest Lifetime Weight _____ Are you trying to lose weight? Yes/No
How many hours a week do you work? _____ How many hours a week do you drive? _____
Do you engage in meditation or prayer? Yes/No

Allergies

Reaction

Medications

Reason

Vitamins, minerals, or supplements you are taking (please list brands, if known)

Name _____ Date of Birth _____ Date _____

Review of Systems: Please note to mark "None" in each section if applicable.

Pulmonary (Lung) Allergies Asthma Difficulty breathing COPD Emphysema
 Other _____ **None**

Cardiovascular (Heart) Heart surgeries Congestive heart failure Murmurs or valve disease Heart attacks Heart disease/problems Hypertension Pacemaker Angina/chest pain Irregular heartbeat
 Other _____ **None**

Neurological (Nerve) Loss of vision One-sided weakness of face or body History of seizures One-sided decreased feeling in the face or body Headaches Memory loss Tremors Vertigo Loss of sense of smell Strokes/TIAs Other _____ **None**

Endocrine (Hormone) Thyroid disease Hormone replacement therapy Steroid replacements Diabetes
 Other _____ **None**

Renal (Kidney) Renal stones Blood in the urine Loss of bladder control Bladder Infections
 Difficulty urinating Kidney disease Dialysis Other _____ **None**

GI (Stomach) Nausea Difficulty swallowing Ulcerative disease Abdominal pain Hernia
 Constipation Diarrhea Pancreatic disease Irritable bowel Liver disease Bloody stool Vomiting
 Loss of bowel control Heartburn Other _____ **None**

Blood Anemia Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) HIV
 Abnormal bruising Sickle-cell Enlarged lymph nodes Hemophilia Blood clots Blood thinners
 Regular aspirin use Other _____ **None**

Dermatological (Skin) Significant burns Significant rashes Psoriasis Other _____ **None**

Musculoskeletal (Bone/Muscle) Osteopenia Osteoporosis Rheumatoid Gout Osteoarthritis Broken bones Spinal fracture Spinal surgery Joint surgery Arthritis Scoliosis Metal implants
 Jaw pain Other _____ **None**

Psychological Alcohol Abuse Drug Abuse Anxiety Depression Suicidal Bipolar Schizophrenia Psychiatric diagnosis
 Psychiatric hospitalizations Other _____ **None**

To what extent are you open to changes to help you improve your health and wellness?
(circle) Eager/ Receptive/ Resistant/ Other _____

Do you have any other concerns about your visit today? _____

I certify that I have answered truthfully and to the best of my ability.

Printed Name _____ **Date** _____

(sign) _____ *(parent/guardian sign)* _____

Discomfort Diagram

Use the letters below to indicate the type and location of your sensations right now:

A = Achy

D = Pins and Needles

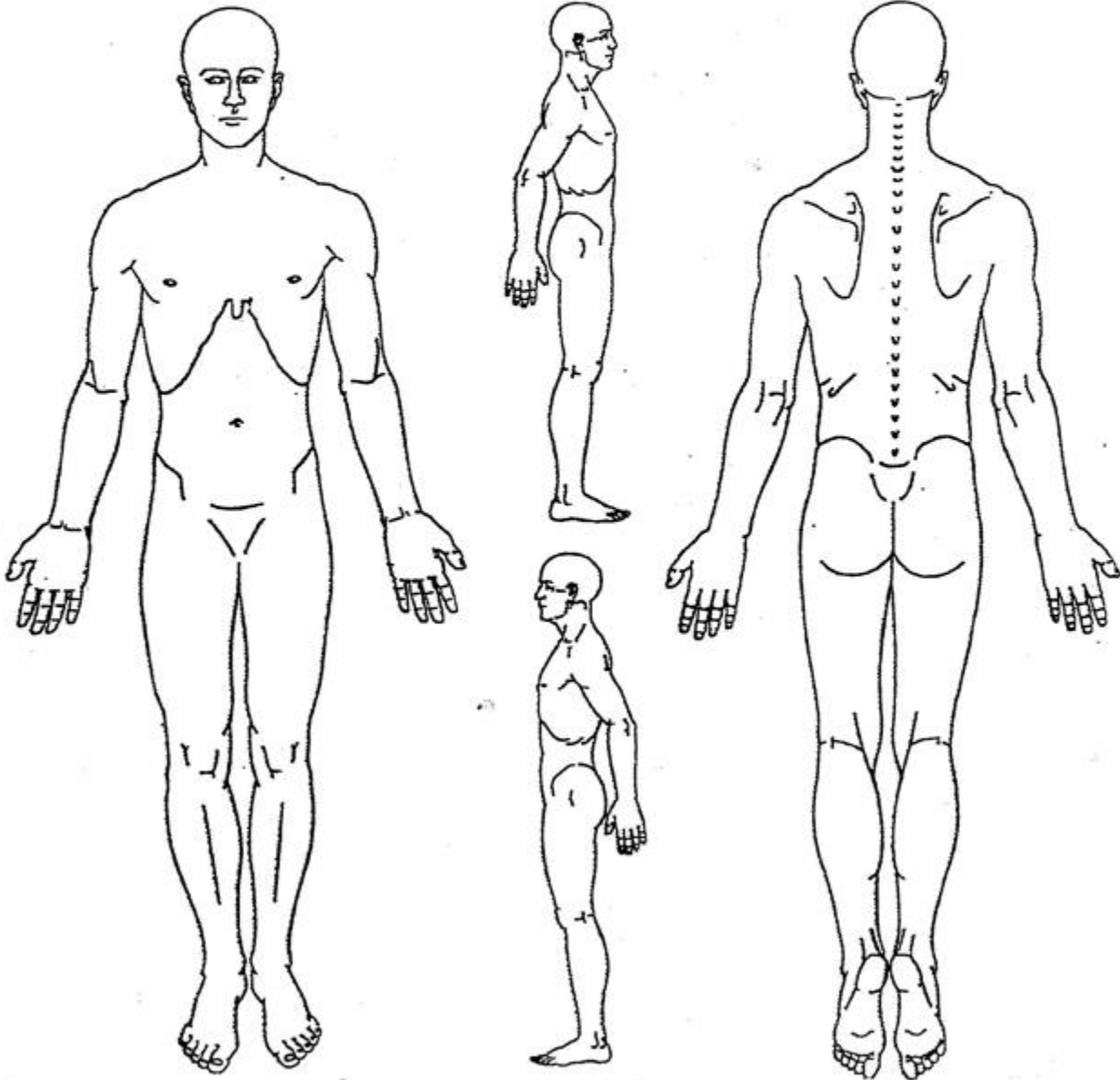
B = Burning

S = Stabbing

N = Numbness

T = Throbbing

O = Other



Name _____ Date of Birth _____ Date _____

Pain Dysfunction Questionnaire (Spine 2004)

This survey asks for your views about how your pain now affects how you function in everyday activities. This information will help you and your doctor know how you feel and how well you are able to do your daily tasks at this time.

Please answer every question by **MAKING AN "X" ALONG THE LINE** to rate how much your pain problem has affected you from 0 to 10 (from having no problems at all to having the most severe problems you can imagine).

BE SURE TO ANSWER ALL QUESTIONS.

	0	1	2	3	4	5	6	7	8	9	10
F1.	Does your pain interfere with your normal work inside and outside the home?										
	_____ _____ _____ _____ _____					_____ _____ _____ _____ _____					
	Work Normally					Unable to work at all					
F2.	Does your pain interfere with personal care (such as washing, dressing, etc.)?										
	_____ _____ _____ _____ _____					_____ _____ _____ _____ _____					
	Take care of my self completely					Need help with personal care					
F3.	Does your pain interfere with your traveling?										
	_____ _____ _____ _____ _____					_____ _____ _____ _____ _____					
	Travel anywhere I like					Only travel to see doctors					
F4.	Does your pain affect your ability to sit or stand?										
	_____ _____ _____ _____ _____					_____ _____ _____ _____ _____					
	No problems					Cannot sit/stand at all					
F5.	Does your pain affect your ability to lift overhead, grasp objects, or reach for things?										
	_____ _____ _____ _____ _____					_____ _____ _____ _____ _____					
	No problems					Cannot do at all					
F6.	Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?										
	_____ _____ _____ _____ _____					_____ _____ _____ _____ _____					
	No problems					Cannot do at all					
F7.	Does your pain affect your ability to walk or run?										
	_____ _____ _____ _____ _____					_____ _____ _____ _____ _____					
	No problems					Cannot walk/run at all					
P8.	Has your income declined since your pain began?										
	_____ _____ _____ _____ _____					_____ _____ _____ _____ _____					
	No decline					Lost all income					
P9.	Do you have to take pain medication every day to control your pain?										
	_____ _____ _____ _____ _____					_____ _____ _____ _____ _____					
	No medication needed					On pain medication throughout the day					
P10.	Does your pain force you to see doctors much more often than before your pain began?										
	_____ _____ _____ _____ _____					_____ _____ _____ _____ _____					
	Never see doctors					See doctors weekly					
P11.	Does your pain interfere with your ability to see the people who are important to you as much as you would like?										
	_____ _____ _____ _____ _____					_____ _____ _____ _____ _____					
	No problem					Never see them					
F12.	Does your pain interfere with recreational activities and hobbies that important to you?										
	_____ _____ _____ _____ _____					_____ _____ _____ _____ _____					
	No interference					Total interference					
F13.	Do you need the help of your family and friends to complete everyday tasks (both housework and outside work) because of your pain?										
	_____ _____ _____ _____ _____					_____ _____ _____ _____ _____					
	Never need help					Need help all the time					
P14.	Do you now feel more depressed, tense, or anxious than before your pain began?										
	_____ _____ _____ _____ _____					_____ _____ _____ _____ _____					
	No depression/tension					Severe depression/tension					
P15.	Are there emotional problems caused by your pain that interfere with your family, social, or work activities?										
	_____ _____ _____ _____ _____					_____ _____ _____ _____ _____					
	No problems					Severe problems					

FSC _____ PC _____ Total _____

Name _____ Date of Birth _____ Date _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Kutu Chiropractic LLC's Notice of Privacy Practices, which has an effective date of 9/21/13 and which describes how my health information may be used and disclosed.

I understand that Kutu Chiropractic LLC has the right to change the Notice of Privacy Practices at any time, that a copy of any updated version will be available on the website, and that I may contact you at any time to request a current Notice of Privacy Practices.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Signature of Patient or Patient's Representative

Date

Print Name

Relationship to Patient (If not signed by the Patient)

Name _____ Date of Birth _____ Date _____

Responsibility for Payment

I understand that I am responsible to verify my insurance eligibility and coverage. If my insurance company denies any portion of my bill, denies visits or medical necessity, applies an unexpected portion to deductible, or does not pay for another reason not here listed, the following applies: I understand that the terms of coverage conveyed to me by this office or by a representative/website from my insurance carrier do not guarantee payment or accuracy. Final payment determination is made by my insurance company upon receipt of the claim and review of documents. I agree to pay any unpaid charges.

_____ Initial to accept

Assignment of Benefits

I hereby authorize and direct my insurance company to pay directly to Kutu Chiropractic such sums as may be due for services rendered. Any funds I receive as payment for services, I agree to promptly direct to Kutu Chiropractic. Any overages may be applied to any non-covered charges.

_____ Initial to accept

Insurance Follow-Up

I understand that it is my responsibility to follow up with my insurance company on incorrectly applied payments, underpayments, and denied charges. I agree to pay the difference between contracted amounts and payments provided to Kutu Chiropractic from my insurance company. As a courtesy Kutu Chiropractic may make an attempt to correct my insurance company's errors, but I understand that I am responsible to coordinate appeals with the insurance company with whom I have contracted.

_____ Initial to accept

Failure to Pay

If I suspend or terminate my treatment, any fees for services will come immediately due and payable. I understand that I am fully responsible for any costs to collect my bill. Costs may include, but are not limited to collection agency fees, attorney's fees, and court costs deemed necessary by Kutu Chiropractic to collect my bill. I understand that I will be charged a \$30 late fee per month for any balances due past 30 days. I additionally understand that I will be charged interest of 5% per year on any unpaid balances.

_____ Initial to accept

Designation of Authorized Representative

I designate Dr. Jolene Kutu and Kutu Chiropractic to the full extent permissible under the Employee Retirement Income Security Act of 1974 (ERISA) and as provided in 29 CFR 2560-503-1(b) 4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any health care expenses incurred as a result of the services I receive at Kutu Chiropractic. These rights include acting on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such health care reimbursements.

_____ Initial to accept

Contacting You

I agree to update Kutu Chiropractic with any contact changes. I give permission to Kutu Chiropractic to send me mail and send emails. I understand that Kutu Chiropractic may call. Financial statements will be sent to my address on file. I understand I am responsible to update the office with changes to address, phone, and email. I further understand if I fail to update my information, my insurance company may deny my bill and I will be responsible for charges.

_____ Initial to accept

Informed Consent: Permission to Treat

I hereby authorize Kutu Chiropractic, including Dr. Kutu and staff, to treat my conditions as deemed appropriate. I certify that the information given to Kutu Chiropractic is correct and complete to the best of my knowledge. I will not hold Kutu Chiropractic responsible for any pre-existing medically diagnosed conditions or any errors or omissions that I may have made in the completion of any documents.

_____ Initial to accept

Informed Consent: Understanding the Risks

Chiropractic, along with other types of health care, is associated with potential risks. There are also risks of non-treatment by Kutu Chiropractic or other health care providers and delay of other services. Chiropractic is generally considered remarkably safe though I understand that, as in practice of all health care, there are some risks to treatment. Sometimes patients experience post treatment soreness. I will tell the doctor if I experience soreness. Occasionally treatment may aggravate or cause an injury, for example to a joint, ligament, tendon, or other soft tissue. Adjustments, in rare cases, may cause a fracture. Care is taken to minimize these risks. All X-rays are harmful radiation and have associated radiation risks. Ice or heat may cause minor skin burns. Based on the latest research, stroke is not considered a side effect of chiropractic care. Please tell Dr. Kutu all your symptoms, even those you deem unrelated. Any side effects to treatment should be reported to Kutu Chiropractic promptly. 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 exam and procedures based the doctors opinions at the time, based on the facts then known, and acting in my best interest. I understand that when appropriate Dr. Kutu or Kutu Chiropractic may refer me to another provider and I agree to follow up on these referrals. I understand that Kutu Chiropractic does not promise any cure for any symptom, condition, or disease as a result of this treatment. I understand that Kutu Chiropractic attempts to provide me with their very best care.

_____ Initial to accept

File Property

All health care files are the property of Kutu Chiropractic and will remain on the property of this office.

_____ Initial to accept

Keeping my Appointments- Rescheduling and No-Show Fees

I understand that keeping my appointments is important to the success of my prescribed treatment plan. I agree to pay **\$20 for rescheduling without 24 hours notice** and **\$35 if I do not show up** for my appointment.

_____ Initial to accept

Copy of This Agreement for your Records

I understand that Kutu Chiropractic is offering me a copy of these agreements including HIPAA Notice of Privacy Practices and I have let them know if I would like a copy for my records. Further, I understand that this information is available to me by request at a later date.

_____ Initial to accept

I read and understood this entire document. I, _____, _____ accept and consent to all of the above.
Patient printed name Date of birth

Signature of patient

Date

Signature of staff

Date

I hereby authorize Dr. Jolene Kutu, Kutu Chiropractic LLC, and whomever she may designate as assistants to administer examinations and treatment as deemed necessary to the minor of which I am parent or legal guardian.

Signature of guardian if applicable

Date

Printed name of guardian

Date