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: Single
Circle: Full-time Student/Part-time Student/_____________
Employer: None **Occupation**: None
Language Circle: English/______________
Smoking status Current everyday smoker ☐ Current someday smoker ☐ Former smoker ☐ Never smoked

Frequency (if current)
☐ 1-5 cigarettes/day ☐ 6-10 cigarettes/day ☐ ½ pack/day ☐ 1 pack/day
☐ 1 ½ pack/day ☐ 2 pack/day ☐ 2 ½ pack/day ☐ 3+ pack/day

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
Parents/Guardians____
Names and Ages of Siblings ____
Pediatrician _________________Phone # ____________ May we contact your child's Doctor? Yes/No

Has the patient 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)

__ Lying on back	__ Getting in/out of car	__ Housework	__ Walking	__ Standing
__ Lying on side	__ Gripping	__ Sleeping	__ Squatting	__ Sneezing
__ Turning in bed	__ Dressing self	__ Pulling	__ Bending forward	__ Coughing
__ Laying on stomach	__ Kneeling	__ Reaching	__ Bending backward	__ Reading
__ Exercise	__ Stretching	__ Computer use	__ Stress	__Sit to Stand
__ Moving Neck	__ Getting in/out of bed	__Moving Back	__ 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)

__ Lying on back	__ Getting in/out of car	__ Housework	__ Walking	__ Standing
__ Lying on side	__ Gripping	__ Sleeping	__ Squatting	__ Sneezing
__ Turning in bed	__ Dressing self	__ Pulling	__ Bending forward	__ Coughing
__ Laying on stomach	__ Kneeling	__ Reaching	__ Bending backward	__ Reading
__ Exercise	__ Stretching	__ Computer use	__ Stress	__Sit to Stand
__ Moving Neck	__ Getting in/out of bed	__Moving Back	__ 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**____________________________

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)

__ Lying on back	__ Getting in/out of car	__ Housework	__ Walking	__ Standing
__ Lying on side	__ Gripping	__ Sleeping	__ Squatting	__ Sneezing
__ Turning in bed	__ Dressing self	__ Pulling	__ Bending forward	__ Coughing
__ Laying on stomach	__ Kneeling	__ Reaching	__ Bending backward	__ Reading
__ Exercise	__ Stretching	__ Computer use	__ Stress	__Sit to Stand
__ Moving Neck	__ Getting in/out of bed	__Moving Back	__ 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 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)

__ Lying on back	__ Getting in/out of car	__ Housework	__ Walking	__ Standing
__ Lying on side	__ Gripping	__ Sleeping	__ Squatting	__ Sneezing
__ Turning in bed	__ Dressing self	__ Pulling	__ Bending forward	__ Coughing
__ Laying on stomach	__ Kneeling	__ Reaching	__ Bending backward	__ Reading
__ Exercise	__ Stretching	__ Computer use	__ Stress	__Sit to Stand
__ Moving Neck	__ Getting in/out of bed	__Moving Back	__ 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?____

Name ______________________________**Date of Birth** ____________**Date**______________________

Medical History (check all that apply)
Name of Obstetician/Midwife____
Were there any complication during pregnancy?____
Were there any complications during labor and delivery?______________________________________
Birth Weight_____________ Weeks Gestation___________wks
Forceps? Yes/No Vacuum Extraction? Yes/No C-section? Yes/No If yes: Emergency/Planned
Breastfed? Yes/No If yes, for how long: Current/_____________
Tongue tie? Yes/No Revised? Yes/No Lip tie? Yes/No Revised? Yes/No

	Current	Past		Current	Past		Current	Past
Birth Defect	☐	☐	Ear Infections	☐	☐	Asthma/Allergies	☐	☐
Colic	☐	☐	Scoliosis	☐	☐	Digestive Problems	☐	☐
Bed Wetting	☐	☐	Seizures	☐	☐	ADHD	☐	☐
Car Accident	☐	☐	Chronic Colds	☐	☐	Recurring Fevers	☐	☐
Temper Tantrums	☐	☐	Headaches	☐	☐	Growing/Back Pains	☐	☐
Genetic Disorders	☐	☐	Other	☐	☐ ____________________			

Surgical History____
____

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? _______ Juice?________ Milk?_________
Do you exercise/sports? 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? ____ Are you trying to lose weight? 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*** ____________________

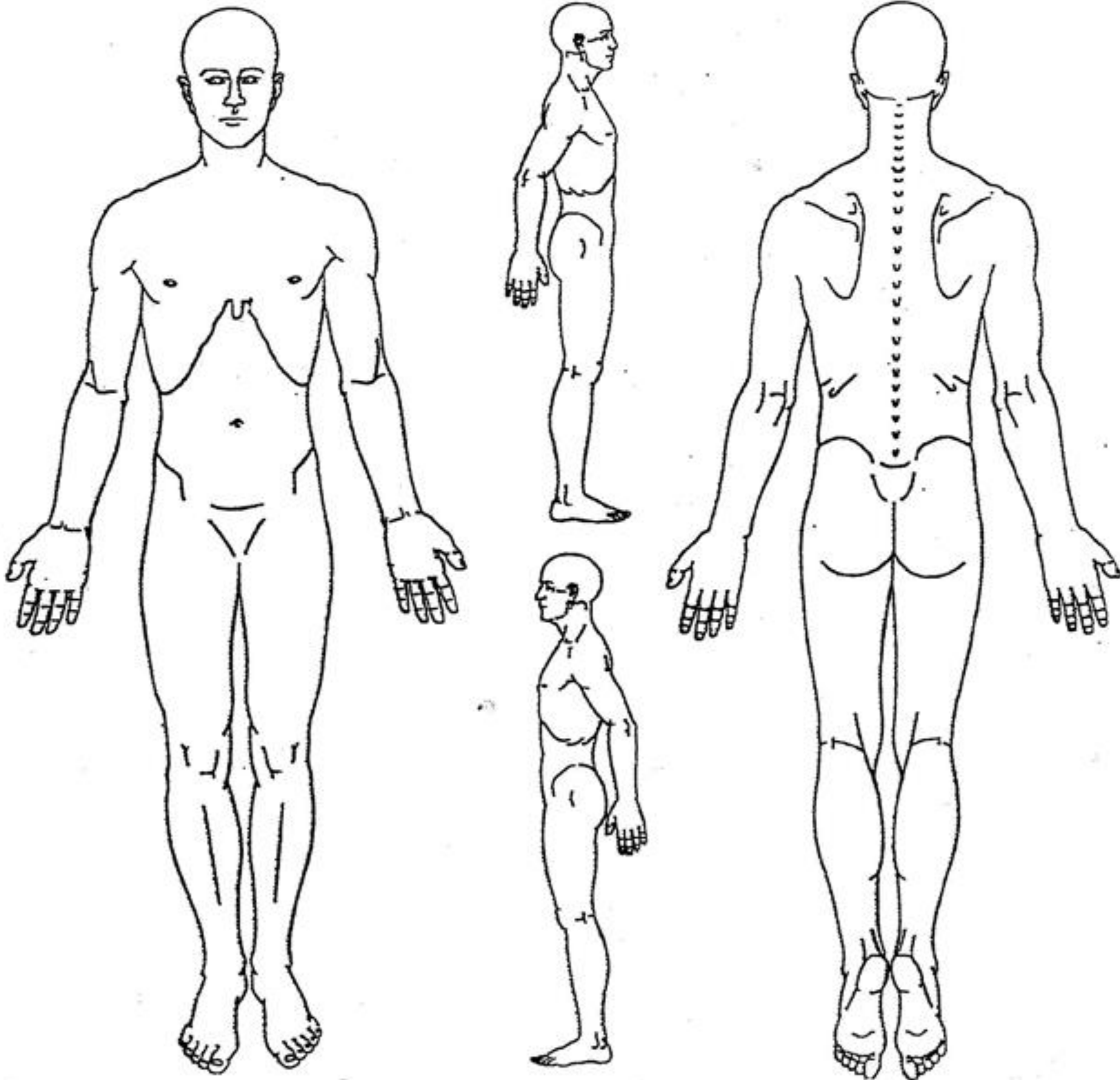
(sign) ___________________________________ ***(parent/guardian sign)*** ____________________________

Name ______________________________Date of Birth ____________Date______________________

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 Questionaire (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 — Can not sit/stand at all

F5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

]____________]____________]____________]____________]____________]

No problems — Can not do at all

F6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

]____________]____________]____________]____________]____________]

No problems — Can not do at all

F7. Does your pain affect your ability to walk or run?

]____________]____________]____________]____________]____________]

No problems — Can not 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 Kuty 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 Kuty 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 Kuty Chiropractic such sums as may be due for services rendered. Any funds I receive as payment for services, I agree to promptly direct to Kuty 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 Kuty Chiropractic from my insurance company. As a courtesy Kuty 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 Kuty 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 Kuty and Kuty 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 Kuty 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 Kuty Chiropractic with any contact changes. I give permission to Kuty Chiropractic to send me mail and send emails. I understand that Kuty 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 Kuty Chiropractic, including Dr. Kuty and staff, to treat my conditions as deemed appropriate. I certify that the information given to Kuty Chiropractic is correct and complete to the best of my knowledge. I will not hold Kuty 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 Kuty 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. Kuty all your symptoms, even those you deem unrelated. Any side effects to treatment should be reported to Kuty 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. Kuty or Kuty Chiropractic may refer me to another provider and I agree to follow up on these referrals. I understand that Kuty Chiropractic does not promise any cure for any symptom, condition, or disease as a result of this treatment. I understand that Kuty Chiropractic attempts to provide me with their very best care.
________________ Initial to accept

File Property
All health care files are the property of Kuty 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 Kuty 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 Kuty, Kuty 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**