Patient Registration: *Please complete entire form.* **Today's Date**_____

Name:_____ **Referred by:**_____

Date of Birth:_____ **Gender:** M F **Marital Status:** S M D W Sep **SSN:**_____

Address:_____ **City**_____ **State**_____ **Zip**_____

Home #:_____ **Cell #:**_____ **Email:**_____

Student Status: Non-student FT PT **Employment:** FT PT Unemployed Military Retired Self Employed

Employer:_____ **Occupation:**_____

Insurance #1:_____ **Insurance #2 :**_____

Chief Complaint:_____

When this began: _____ **How it began:** Work Auto Other _____

Have you had anything similar to this before? No Yes, Explain_____

Other treatments for this problem: MD ER Chiropractor Urgent Care Medication Injections Surgery PT Massage None _____

The pain is: Sharp Dull Aches Burns Shoots Throbs Stabs Sore Stiff Other_____

How often is it present? Constant-100% of time Frequent-75% Intermittent-50% Occassional-25%

Does it radiate or shoot to other areas of the body? Rt arm Lt arm Rt leg Lt leg *Pain* *Numb* *Tingle* None Other_____

Pain is aggravated by? Sitting Standing Laying Sleeping Walking Bending Lifting Twisting Overuse _____

Pain is reduced by? Heat Ice Rest Stretching Meds _____

This problem affects my ability to: Work School Sleep Be active Daily activities Recreation Childcare _____

Health History

Allergies: None _____

Current Medications/Supplements: None _____

_____

Past Surgeries/Hospitalizations: None _____

_____

Past Accidents/Trauma: None _____

_____

Family History

(family = parent, sibling)

	Me	Family		Me	Family
Arthritis	( )	( )	Heart Disease	( )	( )
Asthma	( )	( )	High Blood Pressure	( )	( )
Bleeding Disorder	( )	( )	Seizures/Epilepsy	( )	( )
Cancer	( )	( )	Stroke	( )	( )
Diabetes	( )	( )	Tuberculosis	( )	( )

None Apply ( )

Social History

Do you smoke? Never used Former user Current user # **Packs per day** _____

Do you use smokeless tobacco? Never used Former user Current user **Explain**_____

Do you drink alcohol? No Yes, _____

Do you use recreational drugs? No Yes, _____

What is your exercise routine? None _____

REVIEW OF SYSTEMS

Name_____ **Date**_____

Are you *currently* experiencing any of these symptoms? ***(Answer each section)***

General: *(constitutional)*
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Low Back Pain/Stiffness
- ☐ Mid Back Pain/Stiffness
- ☐ Neck Pain/Stiffness
- ☐ Arm Problems _____
- ☐ Leg Problems _____
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones_____
- ☐ Other: _____
- ☐ *None in this Category*

Neurological:
- ☐ Numbness or tingling sensations
- ☐ Loss of Feeling
- ☐ Dizziness or light headed
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Other: _____
- ☐ *None in this Category*

Mind/Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____
- ☐ *None in this Category*

Genitourinary:
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/strain w Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: _____
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains
- ☐ Rapid or Heartbeat changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ Other: _____
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other: _____
- ☐ *None in this Category*

Eyes and Vision:
- ☐ Wear contacts/glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other: _____
- ☐ *None in this Category*

Ears, Nose and Throat:
- ☐ Bleeding gums / mouth sores
- ☐ Bad Breath or bad taste
- ☐ Dental Problems
- ☐ Swollen throat or voice change
- ☐ Swollen glands in neck
- ☐ Ringing in the ears
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Sinus / Allergy problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other: _____
- __ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive Thirst or urination
- ☐ Cold Extremities
- ☐ Heat or Cold intolerance
- ☐ Change in hat or glove size
- ☐ Dry skin
- ☐ Glandular or hormone problem
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other: _____
- ☐ *None in this Category*

Skin and Breasts:
- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change of appearance of a mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other: _____
- ☐ *None in this Category*

Women Only:

Are currently you pregnant?
- ☐ **Yes -** ***Due Date*** __/____/____
- ☐ **No -** ***Last Menstrual Period*** __/____/____
- ☐ Infertility
- ☐ Painful or Irregular periods
- ☐ Vaginal Discharge
- ☐ Other: _____
- ☐ *None in this Category*

 # Pregnancies: _____
 # Children: _____

Comments:_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient/Guardian Signature _____ Date_____

Patient Name_____ Guardian Name_____

Before this office begins any health care operations we require you to read and sign this form stating that you understand the items below. If you refuse to sign this form the doctor reserves the right to refuse care.

Acknowledgment of Assignment of Benefits:
I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. By signing below I hereby authorize the assignment of benefits for services rendered to me to be paid directly to **Dr. Koester** and/or **Koester Chiropractic** by any first-party, second-party and/or third-party carriers (all insurance companies, attorneys, etc.). I further acknowledge that I am fully responsible for all services rendered. I understand that I may receive a billing statement for services applied to my deductible, co-payments, or any balance due as stated by the insurance company as my responsibility. In the event I receive payment for any services rendered I agree to promptly remit payment within 5 business days to **Koester Chiropractic** I understand that I am responsible for collection fees, court costs and reasonable attorney fees to collect unpaid accounts. The return check fee is $30.

X-rays Studies:
I give consent to **Koester Chiropractic** to perform x-rays as deemed necessary, declare to the best of my knowledge that I am not pregnant (or my child is not pregnant) and have no known limitations or contraindications for x-ray evaluation. I understand that in the event x-rays are taken that the services of a qualified radiologist from *Diagnostic Imaging Inc.* may be utilized for a second opinion or further interpret my x-rays and give consent for their release.

Acknowledgment of Notice of Privacy Practices:
We are very concerned with protecting your personal health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone. Also in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), updated September 23, 2013, this office is obliged to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

CMS-1500 Health Insurance Claim Form: By signing below I acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File." Box 12 reads as follows: "Patient's or Authorized Person's Signature - I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 reads as follows: "Insured's or Authorized Person's Signature - I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

Written Consent: Appointment of Representation
By signing this form I am providing written consent allowing this provider to act on my behalf as my representative in order to (1) obtain insurance coverage and/or benefit information (deductible, amount of deductible met, copay, co-insurance, insurance limitations, etc.); (2) request and/or perform an appeal/review/reconsideration to an insurance company; (3) prepare or complete any necessary forms to obtain prior authorizations, precertifications, referrals and/or payment; (4) initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Acknowledgement: By signing below I acknowledge that I understand and agree with the policies and procedures outlined in this Terms of Acceptance form. By signing below I acknowledge and certify that all the information given to the office/ provider in the INTAKE forms are true and accurate to the best of my knowledge.

Patient/Guardian Signature_____Date_____

Patient Name _____ Date_____

Informed Consent for Chiropractic Services

By reading below I have been made aware:

1. That the process of delivering a "Chiropractic Adjustment/Manipulation" may be performed manually, with a table mechanism, or with an instrument to the vertebra(e) of the spine and/or associated structures (arms, legs, etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment "Supportive Therapies and/or Adjunctive Modalities" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of electricity, traction, motion, nutritional advice, heat or cold;
3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
4. That the chiropractor has made no guarantee of a positive outcome from treatment;
5. That I have been afforded ample opportunity for questions and answers; and
6. That the above risks of the treatment procedures, options, and financial obligations have been explained to me.

I consent to the performance of diagnostic and therapeutic procedures deemed reasonable and necessary by the doctor and/or staff under the direction and supervision of the office chiropractor(s) involved in my case.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease or condition as a result of treatment in this office. We will always give you our best care. We work with numerous health care providers and will make the appropriate referral when necessary. If you have any questions on the above items, please ask the doctor. When you have a full understanding, please sign and date below.

Patient/Guardian Signature_____Date_____

Witness Signature_____Date_____