Welcome to Knowles Chiropractic

Richard T. Knowles, D.C.

PATIENT INFORMATION (please print)

Name ____ Today's Date ______________
First MI Last
Address ______________________________________ City ___________ ST _____ Zip ___________

Nickname _______________ Home Phone __________________ Cell Phone _________________

SSN ________-________-________ Email Address ____

Male _____ Female _____ Age ______ Date of Birth ___________ Height ________ Weight ________

Employer ___________________________________ Work Phone ___________________________

Marital Status Single ______ Married ______ Divorced ______ Separated ______ Widowed ______

Spouse's Name ________________ Number of Children ________ Ages of Children ________________

Referral Source: ____

Emergency Contact: ________________________ Relationship ______________________________

Home phone ______________ Work phone ________________ Cell phone _________________

Insurance Information
I intend to pay for my services by:

Cash\ Credit Card ________ Health Insurance _______ Personal Injury\ Auto Accident ____________

Medicare ________ Medicaid\ Badgercare ________ Worker's Compensation ___________

Do you have an HSA or flex FSA? Yes ______ No ______

Are you covered under any other health policy through yourself or spouse? Yes _____ No ______
If you have health insurance, please give your insurance card to our front desk personnel.

Responsible Party for Payment

Name of person responsible for this account ____

Relationship to the patient ____________________________ Phone number ______________________

Address ___________________________________ City __________ State _______ Zip __________

Please answer the questions on the following pages. The information given will help determine if the doctor can help you, how to effectively treat you, what kind of outcome is possible, and/or what referrals to other health care providers may be in your best interest.

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What is the reason for your visit? How did the pain start? (Pain, numbness, aches, dizziness, tingling, etc?)

____

____

Have you received any other treatment for this problem?

____

____

Who are the physicians you are consulting with regarding your health care?

Dr. ______________________________ Dr. ______________________________

Please list all medications you are currently taking.

____

____

Do you have a family history of any of the following?

	Diabetes	Heart	Stroke	High B.P.	Kidney	Cancer	Back
Mother	______	______	______	______	______	______	______
Father	______	______	______	______	______	______	______
Brother	______	______	______	______	______	______	______
Sister	______	______	______	______	______	______	______
Self	______	______	______	______	______	______	______

Lifestyle Factors which influence healing potential and time:

Serving per day:

Fresh Vegetables:______________________________ **Alcohol :** ☐ **Y** ☐ **N**

Fresh Fruit: ______________________________ **How Much:** ______________________________

Protein (Meats): ______________________________ **Smoke:** ☐ **Y** ☐ **N**

Breads, Cereals, Pasta: ______________________________ **How Much:** ______________________________

Exercise (describe specifically what you do and how often you do it) :______________________________

____

Accident Information

Are you being seen for one of the following injuries? ________YES ________NO

_____ Motor Vehicle Accident _____ Workman's Compensation _____ Personal Injury

Date of accident ____________________

Please describe briefly how and where the injury\ accident occurred:______________________________

____

Patient (or Guardian) Signature:______________________________**Date:**______________

Notice of Privacy Policy

I have read, understand, and agree to the Notice of Privacy Practices of Knowles Chiropractic.

Patient (or Guardian) Signature: ______________________________ **Date:** ______________

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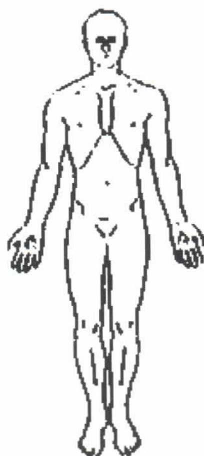
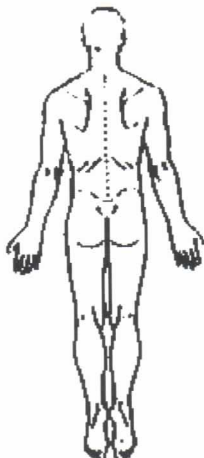
Please indicate the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping
N = Numb



FRONT



BACK

LEFT

RIGHT

On the scales below, please draw a vertical line representing your pain or discomfort.

Rate the pain you are having right **now**:
No pain Unbearable pain
|---|

Rate your pain at its **best** in the past week:
No pain Unbearable Pain
|---|

Rate your **average** pain in the past week:
No Pain Unbearable Pain
|---|

Rate your **worst** pain in the last week:
No Pain Unbearable Pain
|---|

INFORMED CONSENT FOR TREATMENT AND CARE

I hereby request and consent to the performance of medical services, examinations, chiropractic adjustments and other procedures (including various modes of physical therapy and diagnostic x-ray), or physical therapy on me (or the patient named below, for whom I am legally responsible) by the doctors of Knowles Chiropractic, and/or other licensed clinic doctors who now or in the future treat me while employed by, are working or associated with, or serving as a back-up doctor, including those working at the clinic. I have had an opportunity to discuss with the doctor and/ or with other office or clinic personnel the nature and purpose of medical services and examinations, chiropractic adjustments, and other procedures. I authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and I also understand my responsibility to inform this office of any changes in my medical status.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of my treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Patient Name: ______________________________

Patient (or Guardian) Signature: ______________________ **Date:** ____________
(must be signed by parent or guardian for any patient under 18 years of age)

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