

ROBERT T. KAMINSKI, D.C., A.R.T.

KIMBERLY S. LAKE, D.C., A.R.T., C.K.T.P.

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CONFIDENTIAL PATIENT INFORMATION

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

E-mail address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Who referred you? \_\_\_\_\_

Employer: \_\_\_\_\_ Employment Type Student

Address: \_\_\_\_\_  Retired  Full time

Person financially responsible, if other than above  Full time  Part time

Name \_\_\_\_\_  Unemployed

Address \_\_\_\_\_ Phone \_\_\_\_\_

Person to contact in an emergency \_\_\_\_\_ Phone(s) \_\_\_\_\_



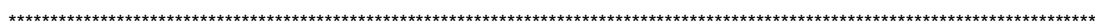
Insurance #1: \_\_\_\_\_ Insured: \_\_\_\_\_

Sex:  Male  Female  Single  Married

Divorced

Your relationship to insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group \_\_\_\_\_



Insurance #2: \_\_\_\_\_ Insured: \_\_\_\_\_

Sex:  Male  Female  Single  Married

Divorced

Relationship to insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

I understand and agree that health and accidental insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Any delinquent balances over 60 days will be charged a 1.5 % monthly interest. I also understand that a missed appointment/late cancellation without 24 notice may result in a charge of \$25.00.

Patient's Signature \_\_\_\_\_

Spouse's or Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Release and Assignment
I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Signature \_\_\_\_\_ Date \_\_\_\_\_

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. For this reason, the terms used are:
Adjustment: An adjustment is the specific application of forces to facilitate the body's correction or vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
A.R.T.: Active Release Techniques is a process of identifying and removing soft tissue abnormalities utilizing specific contacts and ranges of motion.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.
Rehabilitation: personalized and specific strengthening and stabilization program, for in-office or at-home, to aid in recovery.
We do not offer to diagnose or treat any disease or condition other than vertebral subluxation and soft tissue neuromuscular dysfunctions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatments for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. We do not offer advice regarding treatment by others.
Our GOAL is to eliminate dysfunction within your neuromuscular/ biomechanical systems. Our methods are specific adjusting to correct vertebral subluxation, and A.R.T.
I have read and fully understand the above statements. I therefore accept chiropractic care on this basis.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Primary reason for visit (ONE ONLY- If there are other conditions ask at front desk for a separate form)

Mark an "X" on the picture where you continue to have pain.

When did your symptoms appear? \_\_\_\_\_  
How did it start? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

What makes it worse? \_\_\_\_\_

Does the pain radiate? \_\_\_\_\_ To where? \_\_\_\_\_

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Type of Pain:  Sharp  Dull  Throbbing  Numbness  Aching

Burning  Tingling  Cramps  Stiffness  Swelling  Shooting

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your:  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform:

Sitting  Standing  Walking  Bending  Lying Down

What treatment have you received for this condition?  Medication  Surgery

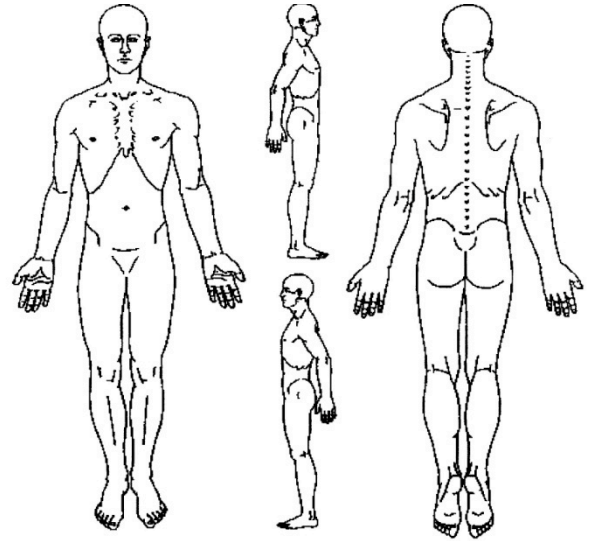
Physical Therapy  Chiropractic  None  Other

Name and address of other doctor(s) who have treated you for your condition:

\_\_\_\_\_  
Name of family Physician \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

What was the date of your last physical? \_\_\_\_\_ Last spinal X-ray? \_\_\_\_\_ Last MRI? \_\_\_\_\_

Are you Pregnant?  Yes  No Due date \_\_\_\_\_



<u>Injuries and surgeries</u>	<u>Description</u>	<u>Date</u>
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries/hospitalizations	_____	_____

Is condition due to an accident?  Yes  No Date \_\_\_\_\_ Type of accident  Auto  Work  Home  Other

To whom have you made a report of this accident?  Auto Insurance  Employer  Work Comp  Other

Attorney Name \_\_\_\_\_ Phone Number \_\_\_\_\_

<u>Exercise</u>	<u>Work Activity</u>	<u>Habits</u>
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking Packs /day _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol Drinks/week _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/ Caffeine drinks Cups/day _____
<input type="checkbox"/> Heavy Reason _____	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High stress

<u>Medications/ dosage</u>	<u>Vitamins/ Herbs/ Minerals</u>	<u>Allergies</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Place a mark in the appropriate box in both columns to indicate if you or family members have a history with the following conditions.

Condition #		<u>PERSONAL</u>		<u>FAMILY</u>
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
1.	Complaints, symptoms (sudden weight loss...)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
2.	Eyes (cataracts, glaucoma...)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3.	Ears, nose, mouth, and throat (tonsils, infections...)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
4.	Cardiovascular (heart attack, stroke...)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
5.	Respiratory (coughing, wheezing...)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
6.	Digestive (stomach pain, diarrhea...)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
7.	Genitourinary (urinary, bladder, sex organs...)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
8.	Musculoskeletal (joint pain, weakness...)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
9.	Integumentary (changes in skin, hair, nails...)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
10.	Neurological (MS, sciatica, Lou Gehrigs...)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
11.	Psychiatric (mental, emotional...)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
12.	Endocrine (thyroid, hormones...)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
13.	Hematological / Lymphatic (anemia, swollen lymph...)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
14.	Allergic Immunologic (immunities, freq. illness...)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
15.	Cancer (any area)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes

For each condition you marked "Yes" to in the PERSONAL column, please answer the following questions. (The back of this page may be used if you need additional space to write).

Condition # \_\_\_\_\_

State the details of your condition? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who did you see for the treatment of the condition? \_\_\_\_\_

\_\_\_\_\_

What were the dates of treatment? \_\_\_\_\_

Condition # \_\_\_\_\_

State the details of your condition? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who did you see for the treatment of the condition? \_\_\_\_\_

\_\_\_\_\_

What were the dates of treatment? \_\_\_\_\_

Condition # \_\_\_\_\_

State the details of your condition? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who did you see for the treatment of the condition? \_\_\_\_\_