Skinner Chiropractic/Southside Chiropractic/Skinner Wellness

3198 Custer Dr. Ste 100
Lexington, KY 40517

Patient Name_____ Date: _____ Email_____

SS #/SIN_____ DOB_____ □ Male □Female Home phone_____ Cell Phone _____

Check appropriate Box: □Minor □Single □Married □Divorced □Widowed □Separated

Patient's Address _____City _____ State_____ Zip_____

Employer Name: _____

Spouse or Patient's Guardian name_____ Spouse's Employer_____

Whom may we thank for referring you? _____

Person to contact in case of an emergency_____ Phone_____

Responsible Party

Name of The Person responsible for this account _____ Relationship to Patient_____

Address _____ Home Phone_____

E-Mail _____ Cell Phone _____

Driver's License # _____ Date of Birth: _____

Is the person currently a patient at our office? □ Yes □ No

Do you have any Medical insurance? □ Yes □ No if yes, complete the following:

Name of the insured_____ Relationship to patient_____

Birthdate_____ SS#/SIN_____ Name of Employer_____ Work Phone _____

Address of Employer_____ State _____ Zip_____

Insurance Company_____ Group #_____ Union or local # _____

Ins. Co. Address _____ City _____ State _____ Zip_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I certify that all information is true and correct. I hereby authorize the release of any information required by this office. I also authorize my benefit payments to be made directly to this clinic. If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct my insurance company to make out the check to me and mail it to this office. I understand that I am financially responsible for all the services rendered. I agree that if my treatment here is suspended or terminated, bills become immediately due and payable. All x-rays are property of Skinner Chiropractic/Southside Chiropractic/Skinner Wellness. I authorize Skinner Chiropractic/Southside Chiropractic/Skinner Wellness to file a written formal complaint to the insurance commissioner, or Department of Labor, on my behalf. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

X_____
Patient signature

X_____
Patient name printed

Date: _____

X_____
signature of Guardian if applicable

Skinner Chiropractic/South Side Chiropractic/Skinner Wellness

Patient Name: _____ DOB: _____ Date: _____

Chief Complaint: _____

History of Present illness:

Location: _____
(Where is the pain/problem?)

Quality: _____
(Example: normal vs abnormal color, activity, etc..)

Severity: _____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: _____
(How long have you had this pain/ problem? When did it start?)

Timing: _____
(Does the pain/problem occur at a specific time?)

Context: _____
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms: _____
(What other associated problems have you been having?)

Aggravating factors: _____
(What makes the pain/problem worse? Have you had previous episodes?)

Relieving factors: _____
(What makes the pain/problem better?)

Complete this section if due to an accident

Type of accident:
- o Auto
- o Workers Comp
- o Fall
- o Other: _____

Date of accident: _____

Brief description of accident:
_____
_____
_____
_____
_____

Past Medical History

Please check the box if you have had any of the following:

- ☐ Measles/Mumps
- ☐ Chicken pox
- ☐ Whooping Cough
- ☐ Scarlet Fever
- ☐ Rheumatic fever
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ If yes, last xray? _____
- ☐ Asthma
- ☐ Bronchitis
- ☐ Anemia
- ☐ Blood/Plasma Transfusion
- ☐ Bleeding Tendency
- ☐ Ulcer
- ☐ Hepatitis
- ☐ Recurrent Bladder Infection
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Back trouble
- ☐ Migraine headaches
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Mitral valve prolapse
- ☐ Peripheral Vascular disease
- ☐ Stroke
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Glaucoma
- ☐ Cancer

Other:
_____
_____
_____
_____

Previous Hospitalizations/Surgeries/Serious Illnesses

Please include location and date

_____
_____
_____

_____
_____
_____

Health Screenings:

Last pap:	Last colonoscopy:	Last pneumonia shot:
Last mammogram:	Last PSA/DRE:	Last tetanus shot:
Last bone density:	Last Flu shot:	

_____ _____
Signature of Provider Date

Skinner Chiropractic/South Side Chiropractic/Skinner Wellness

Patient Name: _____ DOB: _____ Date: _____

Allergies:

_____

_____

Medications: (include nonprescription)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Social History:

Occupation: _____

Marital Status: M S W D

Alcohol Use: Never: ___ Rarely: ___ Moderate: ___ Daily: ___

Type: _____

Tobacco Use: Never: ___ Current: _____ packs per day x ____ yrs

Former: ____ packs per day x ___ yrs

Use of Drugs Never: ___

Type/Frequency: _____

Excessive Exposure at home or at work to: Fumes: _____

Dust: _____ Solvents: _____ Airborne Particles: _____

Noise: _____

Family Medical History:

	Age	Disease	If deceased, cause of death
Mother			
Father			
Brother			
Sister			
Children			
Other			

Review of Systems (Check here ☐ if no symptoms to report)

Please check the box if you have had any of the following in the past 1-2 months

- ☐ Asthma
- ☐ Stuffy nose
- ☐ Hay fever
- ☐ Sore throat
- ☐ Chronic cough
- ☐ Chest congestion
- ☐ Frequent sneezing
- ☐ Itchy/watery Eyes
- ☐ Sinus drainage
- ☐ Earache/ear infection
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Chest pain
- ☐ Fatigue
- ☐ Malaise
- ☐ Weakness/tiredness
- ☐ Lightheadedness
- ☐ Irritability
- ☐ Constipation
- ☐ Diarrhea
- ☐ Burning with urination
- ☐ Blood in urine
- ☐ Blood in stool
- ☐ Feeling foggy
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Numbness
- ☐ Tinging
- ☐ Pins/needles in hands/feet
- ☐ Muscle aches
- ☐ Joint pain
- ☐ Low back pain
- ☐ Neck pain
- ☐ Wrist/hand pain
- ☐ Elbow pain
- ☐ Shoulder pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle/foot pain
- ☐ Pain between shoulder blades

_____ _____

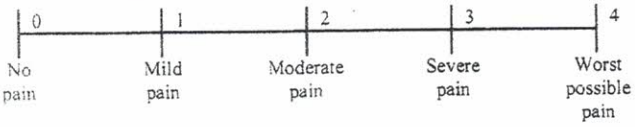
Signature of Provider Date

Functional Rating Index

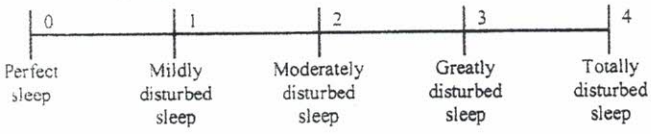
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

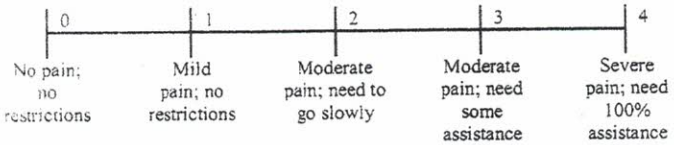
1. Pain Intensity



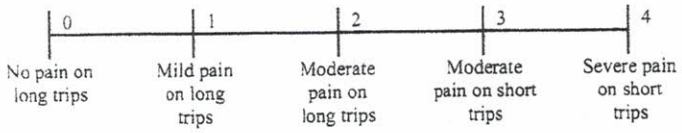
2. Sleeping



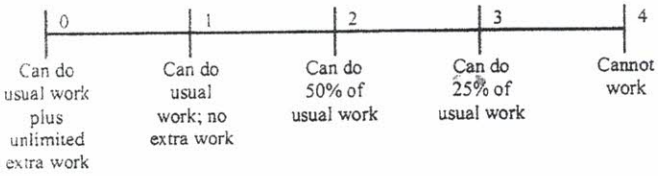
3. Personal Care (washing, dressing, etc.)



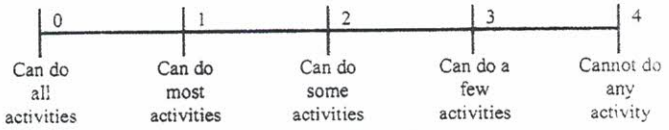
4. Travelling (driving, etc.)



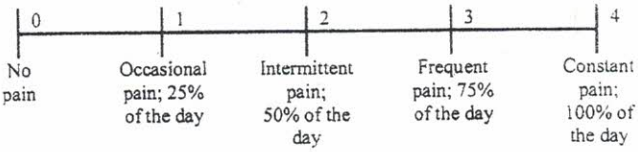
5. Work



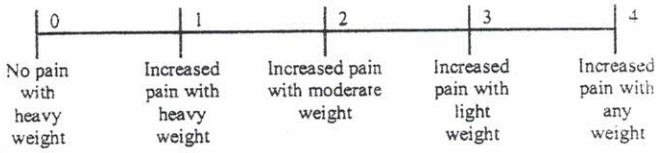
6. Recreation



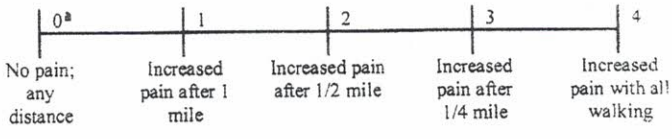
7. Frequency of Pain



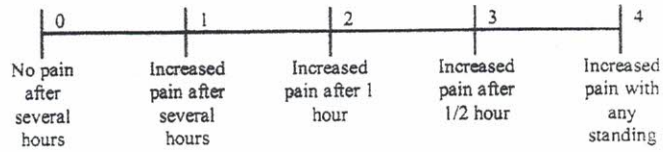
8. Lifting



9. Walking



10. Standing



_____ _____

Patient's Signature **Date**

For Office Use Only:

Practitioner ID#: _____

Total Score _____ **/ 40**

Clinical Diagnosis Codes:

Patient ID#: _____

Health Care Authorization

3198 Custer Dr. Lexington, KY 40517
Tel: (859) 231-6996-Fax: (859) 2554104

Patient's Name	Social Security Number	Date of Birth
_____	_____	_____

The patient identified above authorizes the Chiropractic Practice shown above to use and/or disclose Protected Health Information in accordance with the following:

Specific Authorization

___ I give permission to the above named Chiropractic Practice to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives or other health related information.

___ (OPEN ROOM AUTHORIZATION-OPTIONAL): I give the above named Chiropractic Practice permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.

___ By signing this form, I am giving the above named Chiropractic Practice permission to use and disclose my information in accordance with the directives listed above.

Expiration: The Authorization shall expire on the following date: 12-31-2020.

Right to Revoke Authorization: You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on you authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of the above named Chiropractic Practice. The written notice must contain the following information:

1. Your name, social security number, and date of birth;
2. A clear statement of your intent to revoke this AUTHORIZATION;
3. The date of your request;
4. Your signature

The revocation is not effective until the Privacy Official receives it.

This AUTHORIZATION is requested by the above named Chiropractic Practice for its own use/disclosure of Protected Health Information; you have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, the Chiropractic Practice shown above will not refuse to provide treatment.

You have the right to inspect and/or copy the Protected Health Information to be used/disclosed.

*****A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU*****

Name of Patient_____

Signature of Patient_____ Date_____

Signature of Personal Representative_____