Kaurich Chiropractic And Wellness Center

Tell Us About You

First: _____ M: _____ Last: _____

Nickname: _____ Birth Date: _____ Age: _____ Sex: ☐ Male ☐ Female

Current Address: _____

City: _____ State: _____ Zip: _____ SS#: _____-_____-_____

Primary Telephone: _____-_____-_____ H/W/C Alt. Telephone: _____-_____-_____ H/W/C

Email: _____ Who may we thank for referring you? _____

Marital Status: ☐ Single ☐ Divorced ☐ Widow Married to: _____

# of Children: _____ Ages of Children: _____

Employment Status: ☐ Full-time ☐ Part-time ☐ Not Employed ☐ Self ☐ Retired

Occupation: _____ Employer: _____

Student: ☐ No ☐ Full-time ☐ Part-time School Name: _____

Emergency Contact: _____ Phone: _____-_____-_____

Emergency Contact is your: ☐ Spouse/partner ☐ Parent ☐ Other: _____

Tell Us Why You're Here

What is the primary reason for your visit? ☐ Health Assessment - OR -

☐ Health problem/symptom: _____

Is this due to a: ☐ Automobile accident ☐ Worker's Comp Accident ☐ Personal injury case ☐ None

When did your pain/symptoms begin (include date if possible)? _____

The overall severity of your complaints/concerns is:

☐ Mild ☐ Mild to moderate ☐ Moderate ☐ Moderately severe ☐ Severe

The overall frequency is: ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

On a scale of 0 to 10, how would you rate your pain/symptoms today? (Please circle a number below)

None = 0 1 2 3 4 5 6 7 8 9 10 = Worst possible

If your symptoms change, when are they worse: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ N/A

Are your symptoms/pain getting: ☐ Better ☐ Worse ☐ Staying the same

Have you had recent treatment for this condition? ☐ No ☐ Yes – please list dates and doctors:

_____

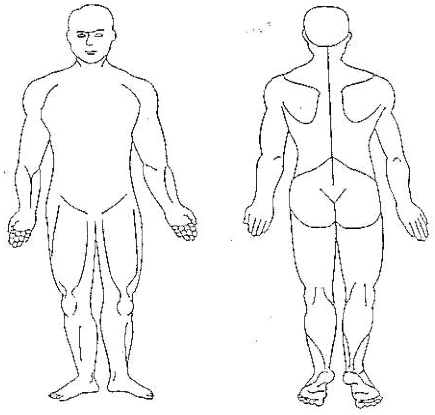
Have you had the same or similar problems in the past? ☐ No ☐ Yes – When: _____

Use the following key to mark your complaints on the diagram at the right:

Pain = P Numbness = N Weakness = W

Soreness = O Stiffness = X Swelling = S

Burning = B Tingling = T



If your complaints include pain, how would you describe it?

(please check all that apply):

☐ Aching ☐ Burning ☐ Dull ☐ Sharp ☐ Shooting

☐ Stabbing ☐ Throbbing ☐ Other: _____

Since your symptoms began, have you noticed any function changes: ☐ Bowel ☐ Bladder ☐ Sexual ☐ N/A

Do work activities aggravate your present complaints? ☐ Yes ☐ No ☐ N/A

How often does your job involve lifting? ☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly

Other job requirements (please check all that apply): ☐ Bending ☐ Carrying ☐ Stooping

☐ Twisting ☐ Turning ☐ Walking ☐ Other: _____

What is your primary work position? ☐ Seated ☐ Standing ☐ Other: _____

Your Activities of Daily Living

Please indicate which activities of daily living are compromised by your current state of health:

☐ Walking	☐ Playing instrument	☐ Swimming	☐ Vacuuming
☐ Sitting	☐ Using telephone	☐ Recreational activities	☐ Washing dishes
☐ Climbing Stairs	☐ Running	☐ Getting in/out of an automobile	☐ Ironing
☐ Chewing	☐ Bending	☐ Driving a car	☐ Carrying groceries
☐ Kneeling	☐ Lying in bed	☐ Riding in a car	☐ Caring for pets
☐ Sleeping	☐ Using computer	☐ Other travel	☐ Cooking
☐ Standing	☐ Exercising	☐ Sewing or crafts	☐ Mowing lawn
☐ Lifting children	☐ Sitting in recliner	☐ Doing laundry	☐ Raking leaves
☐ Reading	☐ Sports	☐ Making beds	☐ Gardening
☐ Shoveling snow	☐ Combing hair	☐ Shaving	☐ In/out of bathtub
☐ Brushing teeth	☐ _____	☐ _____	☐ None apply

Please mark whether you NOW HAVE (○) or had IN THE PAST (□) any of the following conditions/illnesses:

Now	Past		Now	Past		Now	Past	
○	□	Allergies	○	□	Difficulty Speaking	○	□	Prostate Trouble
○	□	Hay Fever	○	□	Sinus Trouble	○	□	Erectile Dysfunction
○	□	Fatigue/Weakness	○	□	Asthma	○	□	Fertility Problems
○	□	Night Sweats	○	□	Wheezing	○	□	Excessive Thirst
○	□	Unexpected	○	□	Chronic Cough	○	□	Thyroid Trouble
		Weight Change	○	□	Shortness of Breath	○	□	Anxiety/Nervousness
○	□	Jaw Pain/TMJ	○	□	Chest Pain/Pressure	○	□	Mood Swings/Irritability
○	□	Sleeping Problems	○	□	Heart Trouble	○	□	Mental/Emotional Difficulty
○	□	Skin Problems	○	□	High Blood Pressure	○	□	Depression
○	□	Loss of Balance	○	□	Low Blood Pressure	○	□	Arthritis
○	□	Dizziness	○	□	Cold Hands/ Feet	○	□	Bone Fracture
○	□	Vertigo	○	□	Abdominal Pain	○	□	Dislocated Joints
○	□	Fainting	○	□	Indigestion/ Upset Stomach	○	□	Autoimmune Disease
○	□	Headaches	○	□	Excess Gas	○	□	Cancer
○	□	Seizures	○	□	Heartburn	○	□	Diabetes
○	□	Loss of Memory	○	□	Constipation	○	□	Fibromyalgia
○	□	Vision Trouble	○	□	Diarrhea	○	□	Multiple Sclerosis
○	□	Hearing Trouble	○	□	Nausea/Vomiting	○	□	Rheumatic Fever
○	□	Ear Infections	○	□	Bedwetting	○	□	Tuberculosis
○	□	Ringing/buzzing in ears	○	□	Urinary Pain/ Frequency	○	□	Other: _____
○	□	Loss of Smell	○	□	Kidney/Bladder Pain	○	□	Other: _____
○	□	Loss of Taste	○	□	Blood in Urine/Stool	○	□	Other: _____
○	□	Difficulty Swallowing	○	□	Menstrual Problems/ Pain	○	□	Other: _____

Additional information and/or description:

_____

_____

_____

Sickness, Injury and Accident History

*Include DATES, DESCRIPTIONS and specify (R)ight side, (L)eft side or (B)ilaterally as applicable.

*Accidents (include automobile, work-related, personal injury, slip and fall, or any serious injury): _____

_____

*Prior illnesses (other than colds and flu): _____

_____

Surgeries and hospitalizations: _____

_____

Tell Us About Your Family Health History

Relative	Illnesses (if no family illnesses, check here: □)	Age	Cause of Death
Mother	_____	_____	_____
Father	_____	_____	_____
Sister 1	_____	_____	_____
Sister 2	_____	_____	_____
Brother 1	_____	_____	_____
Brother 2	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Your Lifestyle

Using a scale from 0 to 10, where 0 equals “awful” and 10 equals “amazing” (please circle):

How would you rate your overall health? 0 1 2 3 4 5 6 7 8 9 10

On a scale of 0 to 10, how would you rate an average day of stress in your life? (Please circle one)

No Stress = 0 1 2 3 4 5 6 7 8 9 10 = Very Stressfull

Where in your body do you feel you hold or carry your stress?_____

Do you feel your problems are from physical stress, chemical stress, emotional stress, or a mixture?_____

How many hours do you sleep each night ?_____ Is it easy to fall and stay asleep?(circle one) YES or NO

What bad habits do you feel you need to release in order to get better ?_____

On a scale of 0 to 10, how would you rate your commitment level of getting your condition corrected? (Please circle one):

Not committed = 0 1 2 3 4 5 6 7 8 9 10 = Very committed

Which is your dominant hand? ☐ Left ☐ Right ☐ Ambidextrous

Do you exercise? ☐ No ☐ Yes – How often? _____

How many caffeinated drinks do you consume: ___ per day How many alcoholic drinks do you consume: ____ per week

Have you ever been to a **doctor of chiropractic** before? ☐ No ☐ Yes – How long ago? _____

Name of prior DC: _____ City/State: _____

Do you see a medical doctor or osteopath? ☐ No ☐ Yes – Date of last visit: _____

Name of MD: _____ City/State: _____

Women only: To your knowledge are you pregnant? ☐ No ☐ Yes – Due date? _____

Communication is Key to a Positive Relationship

Is there anything else you would like us to know? ☐ No ☐ Yes - _____

_____

I do hereby acknowledge that to the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be detrimental to my health. It is my responsibility to inform Kaurich Chiropractic of any changes in my health status.

Name of Patient: **X**_____ Date: **X** _____

Personal Representative: _____ Relationship: _____

Signature: **X** _____ Witness: _____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Kevin Kaurich and/or other licensed doctors of chiropractic who now or in the future work at Kaurich Chiropractic. I understand I will have an opportunity to discuss with Dr. Kevin Kaurich the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect Dr. Kaurich to be able to anticipate and explain all risks and complications, and I wish to rely upon Dr. Kaurich to exercise judgment during the course of the procedure which Dr. Kaurich feels at the time, based upon the facts then known to him, is in my best interest.

I have read, or have had read to me, the above consent. I have had an 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 treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: X _____ Date: X_____

Patient Printed Name: X_____ Witness: _____

For Parents or legal guardians only:

Consent to care for a minor: I hereby authorize Kaurich Chiropractic to administer care as deemed necessary to:

Printed Name of minor patient: X_____ Date X_____

Printed Parent or legal guardian name X_____ Signature X_____

Kaurich Chiropractic, 21421 Cleveland Road, South Bend, IN 46628

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**: _____

Email address:_____ @_____

Preferred Language: _____ **Preferred method of communication for patient reminders (Circle One):** Email / Phone / Mail

Smoking Status (Circle One): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle One): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)

Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please also include any regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit.** (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: **X**_____ Date: **X**_____

For office use only

Height:_____ Weight:_____ Blood Pressure:_____/_____

Authorization, Assignment, Acknowledgment and Understanding

Authorization to release information: Kaurich Chiropractic is authorized to release any information that it deems appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Kaurich Chiropractic, including its designated associates and assistants and hereby release Kaurich Chiropractic from any consequence and/or liability concerning the same.

Assignment of payment: My attorney and/or insurance company are hereby requested to pay directly to Kaurich Chiropractic any monies due it on account, the same to be deducted from any settlement made of my behalf. Further, it is understood and agreed that I shall pay the full amount of the charges, should my condition be such that it is not covered by my insurance policy or if for any reason the insurance company and/or attorney refuses and/or fails to pay my claim. Since Kaurich Chiropractic does not own my Insurance policy, they cannot guarantee my insurance company will pay on my claims per their verification of my benefits. If difficulty does arise in collecting from a carrier, I understand I may be asked to assist in order to rectify the situation. Ultimately, I, the patient, am responsible for all services, including those not reimbursed by third party payers.

Unpaid Insurance Balance: I understand and agree that should there be any unpaid insurance balance for sixty (60) days, such balance shall automatically become my responsibility.

Patient Payments: I understand that I am responsible and must pay any deductible, co-insurance and/or copay that my insurance company makes me responsible for. I also understand that payment is expected at the time of service unless there is a signed payment plan agreement on file with Kaurich Chiropractic.

Returned checks: I understand and agree to pay a $30 "returned check fee" for any checks that I write to Kaurich Chiropractic that are returned to them and that balances over 30 days may be subject to additional collection fees and interest charges.

Past Due Accounts: Accounts not paid within 120 days will automatically be sent to a collection agency.

Medicare Assignment: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I authorize a copy of this authorization to be used in a place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignments below.

X-rays: It is understood and agreed the amount paid to the doctor for x-rays is for the examination and reading of the x-ray only. Since Kaurich Chiropractic is legally responsible for the x-rays, they will remain property of the office. The x-rays may be viewed in the office at Kaurich Chiropractic free of charge in accordance with office HIPAA procedures. In addition, I understand that I can request a **copy** of my x-rays and that copy fees will apply and will be due at the time the request is submitted. I understand that my request for x-rays copies will need to be submitted to Kaurich Chiropractic in writing in accordance with office HIPAA procedures and that they have up to 30 days to respond to this request.

Safety Notice: I understand that chiropractic adjusting tables and office equipment is not intended to be played with or around by children. I agree to supervise my children while I am at Kaurich Chiropractic to prevent any injury from touching adjusting table mechanics or any other office equipment. I understand that Kaurich Chiropractic nor their employees or owners may be held responsible for any injuries that result from lack of proper supervision of children.

Obligations as to services: I hereby acknowledge that I am receiving (or about to receive) health care services at Kaurich Chiropractic and that I have been advised that Kaurich Chiropractic is willing to wait for payment for these services so long as there continues to be a likelihood that payment will be made either by my insurance company and/or out of the settlement of my liability case. I understand and agree that, in the event that:

A. It is determined that there is no insurance company obligation to pay for Kaurich Chiropractic's services;
B. The insurance company for the undersigned refuses to acknowledge an assignment to Kaurich Chiropractic or to take other actions for the protection of the interest of Kaurich Chiropractic;
C. My attorney fails and/or refuses to agree to protect the interest of Kaurich Chiropractic as determined in its sole discretion; or
D. I fail to retain an attorney then payment of services at Kaurich Chiropractic will be made on a current basis and my bill paid in full within thirty (30) days from my last treatment.

I hereby authorize the doctor to treat any condition they may deem appropriate through the use of but not limited to spinal adjustments. The client also agrees to be responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnoses.

By my signature below, I make the foregoing authorizations, assignments and agreements.

X_____ X_____

Patient Name (please print) Patient Signature

X_____ X_____

Date Signed Witness

Appointment Policy

Office visits are scheduled according to the severity of your condition and the program of chiropractic care that the doctor feels is best for you. In order to receive optimum results, it is very important that you follow the care plan the doctor recommends for you. The frequency of your treatment schedule and your commitment level of following doctor's recommendations is of paramount importance to your results.

If for any reason you are unable to keep an appointment, please call Kaurich Chiropractic immediately to reschedule that visit. In order to see the results you are expecting, it is recommended that missed appointments be made up as soon as possible. If obstacles arise that will prevent you from keeping your appointments according to the care plan that is recommended for you, please call us immediately so we can help work out a solution for you.

If you are late for an appointment, our staff will try reaching out to you approximately 15 minutes after your scheduled time. We will call you at the phone numbers you provided on your intake forms and if no answer, a message will be left on voicemail.

If life circumstances require you to end care at our office, please notify our office immediately so we can make note in your file.

Proper health care is a two-way street, meaning that both the doctor and the patient have various responsibilities to uphold if you are to receive maximum benefits. Natural healing requires joint cooperation!

New Patient Orientation

You and a guest will be invited to attend a Wellness Orientation upon starting care in our office. Since chiropractic is probably new to you, it is essential to understand how to help us help you get well faster. We have found that practice members who have attended seem to respond better, because they understand the cause of their problem and what chiropractic can do to help. The purpose of this orientation is to help enlighten you about your body, especially the spine, brain and nervous system. Doctor will explain why constant and chronic levels of physical, chemical and emotional stress everyone experiences everyday leads to damage, degeneration and disease. Friends and relatives are invited to attend as this is a terrific way for them to find out the value of chiropractic care. Just ask at the front desk to reserve a place for your guests.

I have read the Appointment and New Patient Orientation policy

X_____ X_____

Patient Name (please print) Patient Signature

X_____ _____

Date Signed Witness