Whitekettle Chiropractic

Dr. Brett Whitekettle

For Office Use Only:

Patient ID #:

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Patient Information

Date: _____

Name: _____

Address:_____

City: _____ State: _____ Zip: _____

SS#: ____-___-_____ Sex: Male Female

Date of Birth: _____/_____/_____

☐ Single ☐ Married ☐ Separated ☐ Divorced

☐ Widowed ☐ Minor

Race: ☐ African American ☐ Asian ☐ Black

☐ White ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

☐ Other: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other

Employer: _____

Occupation: _____

How did you hear about us? _____

Phone Numbers

Home: (_____) _____

Work: (_____) _____

Cell: (_____) _____

Email: _____

Cell Carrier (ATT, Verizon, etc): _____

Emergency Contact: _____

Emergency Phone: (_____) _____

Insurance Information

Policy Holder's Name:

_____

Policy Holder's Birthdate: _____/_____/_____

Relationship to Patient:

_____

Insurance Company:

_____

Is patient covered by additional insurance?

Yes No

Additional Insurance:

_____

Accident Information

Is your condition due to an accident? Y N

Date of Accident: _____/_____/_____

Type of Accident: ☐ Auto ☐ Work ☐ Other

Accident reported to: ☐ Auto Insurance Co

☐ Employer ☐ Worker's Comp ☐ Other

Claim Number: _____

Attorney Name: _____

Today's Visit

Please rate your pain on a scale of 1-10 for each complaint listed. ***PRIMARY COMPLAINT MUST BE COMPLETED*.**

PRIMARY COMPLAINT: _____ Pain Rating: ____/10

Severity: ☐ Mild ☐ Moderate ☐ Severe

Frequency: ☐ Constant ☐ Occasional ☐ Intermittent ☐ Frequent

Onset: ☐ Sudden ☐ Gradual

How long ago did your problem begin? _____

Select the type of pain this problem causes: ☐ Achy ☐ Burning ☐ Dull ☐ Sharp ☐ Stiff ☐ Throbbing

What sensations are caused by this problem? ☐ Numbness ☐ Pins & Needles ☐ Tingling

Does this pain radiate? If so, where? _____

Is this pain? ☐ Better in the morning ☐ Better during the day ☐ Better at night

What makes this pain worse? _____

What makes this pain better? _____

Anything else pertinent to this complaint? _____

SECONDARY COMPLAINT: _____ Pain Rating: ____/10

Severity: ☐ Mild ☐ Moderate ☐ Severe

Frequency: ☐ Constant ☐ Occasional ☐ Intermittent ☐ Frequent

Onset: ☐ Sudden ☐ Gradual

How long ago did your problem begin? _____

Select the type of pain this problem causes: ☐ Achy ☐ Burning ☐ Dull ☐ Sharp ☐ Stiff ☐ Throbbing

What sensations are caused by this problem? ☐ Numbness ☐ Pins & Needles ☐ Tingling

Does this pain radiate? If so, where? _____

Is this pain? ☐ Better in the morning ☐ Better during the day ☐ Better at night

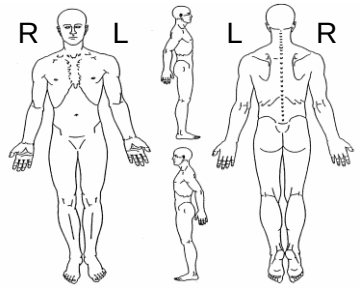
What makes this pain worse? _____

What makes this pain better? _____

Anything else pertinent to this complaint? _____

Pain Diagram

Please circle the areas in which you are experiencing pain.



Health History

Height: _____ ***Weight:*** _____

Please select all choices that apply to the patient:

- ☐ Abdominal Pain
- ☐ Allergies
- ☐ Angina
- ☐ Anorexia
- ☐ Aortic Aneurysm
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Bone Cancer
- ☐ Brain Cancer
- ☐ Breast Soreness
- ☐ Breast Cancer
- ☐ Bulimia
- ☐ Cancer
- ☐ Chest Pain
- ☐ Colitis
- ☐ Colon Cancer
- ☐ Convulsions
- ☐ Type I Diabetes
- ☐ Type II Diabetes
- ☐ Dislocation
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Esophageal Cancer
- ☐ Fainting
- ☐ Gout
- ☐ Hay Fever
- ☐ Headaches
- ☐ Heart Attack
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Hip Pain
- ☐ HIV/AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hypotension
- ☐ Irregular Bowel
- ☐ Irregular Menstruation
- ☐ Irritable Colon
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Kyphosis
- ☐ Lordosis
- ☐ Low Back Pain
- ☐ Lung Cancer
- ☐ Lung Disease
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Painful Urination
- ☐ Peptic Ulcer
- ☐ PMS
- ☐ Polio
- ☐ Prostate Cancer
- ☐ Prostate Issues
- ☐ Rapid Heart Rate
- ☐ Rectal Cancer
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scoliosis
- ☐ Shoulder Pain
- ☐ Sickle Cell Anemia
- ☐ Sinus Trouble
- ☐ STD
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Vaginal Discharge
- ☐ _____
- ☐ _____

Please select all choices that apply to the patient's family (do not include relations by marriage):

- ☐ Abdominal Pain
- ☐ Allergies
- ☐ Angina
- ☐ Anorexia
- ☐ Aortic Aneurysm
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Bone Cancer
- ☐ Brain Cancer
- ☐ Breast Soreness
- ☐ Breast Cancer
- ☐ Bulimia
- ☐ Cancer
- ☐ Chest Pain
- ☐ Colitis
- ☐ Colon Cancer
- ☐ Convulsions
- ☐ Type I Diabetes
- ☐ Type II Diabetes
- ☐ Dislocation
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Esophageal Cancer
- ☐ Fainting
- ☐ Gout
- ☐ Hay Fever
- ☐ Headaches
- ☐ Heart Attack
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Hip Pain
- ☐ HIV/AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hypotension
- ☐ Irregular Bowel
- ☐ Irregular Menstruation
- ☐ Irritable Colon
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Kyphosis
- ☐ Lordosis
- ☐ Low Back Pain
- ☐ Lung Cancer
- ☐ Lung Disease
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Painful Urination
- ☐ Peptic Ulcer
- ☐ PMS
- ☐ Polio
- ☐ Prostate Cancer
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- ☐ Rapid Heart Rate
- ☐ Rectal Cancer
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scoliosis
- ☐ Shoulder Pain
- ☐ Sickle Cell Anemia
- ☐ Sinus Trouble
- ☐ STD
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Vaginal Discharge
- ☐ _____
- ☐ _____

Smoking: ☐ Current Every Day ☐ Current Some Day ☐ Former ☐ Never

Tobacco: ☐ Current Every Day ☐ Current Some Day ☐ Former ☐ Never

Medications (Please list the medication and the dosage, including vitamins & supplements):

_____ _____

_____ _____

_____ _____

Allergies:

_____ _____

_____ _____

_____ _____

Who is your General Physician or Family Doctor? _____

Have you seen a chiropractor before? If so, who? _____

Past Surgical History (please include the type of surgery and approximate date):

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Do you have a pacemaker? ☐ YES ☐ NO

Past Hospitalizations (please include reason for hospitalization and approximate date):

_____ _____

_____ _____

Past Treatments and Diagnostics:

☐ X-Rays	Date: _____	Location: _____
☐ CT Scan	Date: _____	Location: _____
☐ MRI	Date: _____	Location: _____
☐ Discogram	Date: _____	Location: _____
☐ Myelogram	Date: _____	Location: _____
☐ Nerve Block Injection	☐ Botox Injection	
☐ Trigger Point Injection	☐ EMG Needle Exam	
☐ Epidural Injection	☐ Spinal Infusion Pump	

I understand that the information I have provided is current and complete to the best of my knowledge.

Patient Printed Name: _____

Patient Signature: _____

Date: _____

Consent for Chiropractic Treatment

Prior to beginning treatment, you will be given a physical examination that can include taking vital signs, range of motion testing, muscle strength testing, palpation, orthopedic testing, neurological testing and X-rays. Once your condition has been diagnosed, the primary method of treatment will be spinal manipulation, also known as spinal adjustment. An adjustment is a quick, precise movement of the spine over a short distance. Adjustments are usually performed by hand but may be performed by hand- guided mechanical instruments. In addition to spinal manipulation, treatment can also involve other forms of therapy including ultrasound, electrical stimulation, traction, hot and cold packs, hydrotherapy, infrared heat, exercise and nutritional supplements.

All health care procedures carry some degree of risk. The most common side effect of spinal manipulation is short-term muscle soreness. More serious side effects can include bone fractures, muscle strain, ligament sprain, joint dislocation and injury to the discs, nerves or spinal cord. Some manipulations of the upper spine have been associated with injury to the arteries in the neck, which could cause or contribute to stroke. However, documented cases are exceedingly rare, and it has been estimated by researchers that the probability of a spinal adjustment causing a stroke is one in several million.

As for chiropractic therapies other than spinal manipulation, the risks are also very slight but can include skin irritation or burns. Compared to other forms of health care, chiropractic is extremely safe, and complications are generally rare.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics;
- Medical care and prescription drugs such as muscle relaxers, pain killers and drugs to reduce inflammation;
- Surgery;
- Remaining untreated

If you decide to pursue other treatment options, you should discuss the risks and benefits with your medical physician. Remaining untreated carries its own risks and may allow the formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce mobility and induce chronic pain cycles.

If your pre-treatment examination reveals any health issues that would make some forms of chiropractic treatment inadvisable (contraindicated), your chiropractor will explain the risks to you and answer any questions you may have.

Patient Name (please print): _____ Date: _____

Patient Signature: _____

Consent to X-Ray and/or Pregnancy Release

I hereby authorize Whitekettle Chiropractic and whomever the clinician may designate as his/her assistants to take X-rays, and release Whitekettle Chiropractic from all liability.

Patient Signature: _____ Date: _____

Consent for Treatment of Minor Child

I, being the parent, guardian or custodian of the minor being _____, age _____, do hereby authorize, request and direct Whitekettle Chiropractic, its doctors and staff to perform examinations, diagnostic x-rays, and any treatment that in their judgment, is deemed advisable or required. It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests and treatments as will be needed while said minor shown above is under care in the office until legal age is attained.

As legal parent/guardian I realize full responsibility for all charges and payment due.

Parent/Guardian or Custodian Signature: _____ Date: _____

Printed Name of Parent/Guardian or Custodian: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six (6) years.

Patient Name (please print): _____ Date: _____

Parent, Guardian or Patient's Legal Representative: _____

Signature: _____

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS AND MAY BE REPLACED AS NECESSARY TO COMPLY WITH HIPAA REGULATIONS.

Please list below the names of people to whom you authorize Whitekettle Chiropractic to release PHI (Protected Health Information)

_____ _____

_____ _____

I hereby authorize Whitekettle Chiropractic to contact me with appointment reminders and any additional information related to my treatment and care, including billing, via the following *(please provide a valid phone number and/or email address):*

(Circle one)

Telephone: _____ Messages ***MAY / MAY NOT*** be left at this number

Text Message: _____

Email: _____ Whitekettle Chiropractic provides billing statements via email