Kominsky Chiropractic

PATIENT INFORMATION

Full Name:_____ Social Security #_____ Today's Date_____

Address:_____City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Age:_____ Birth Date:_____ Sex:_____ Marital: M S W D (Circle one)

Occupation:_____Employer:_____

Employer's Address:_____Work Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____Contact Number_____

Emergency Contact Name:_____ Address:_____Phone:_____

METHOD OF PAYMENT

Please circle any and all insurance coverage that may be applicable in this case: π Major Medical π Worker's Compensation π Medicare π Auto Accident π Medical Savings Account & Flex Plans π Other_____

Name of Primary Insurance Company:_____

Name of Secondary Insurance Company (if any):_____

AUTHORIZATION, ASSIGNMENT, LIEN, AND RELEASE

I authorize payment of insurance benefits and settlement or judgement proceeds directly to Kominsky Chiropractic. I grant Kominsky Chiropractic an irrevocable lien on any benefits payable to me as a result of my injuries in an amount equal to their fee for treating me. I authorize the doctor to release all information necessary to communicate with personal physicians, attorneys, adjusters, and other healthcare providers and payors and to secure the payment of benefits. This is to serve as a long-term authorization card. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Medical Case History

HISTORY OF PRESENT ILLNESS

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? π Yes π No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder	__Stroke
__Circulatory Problems	__Epilepsy	__Alcoholism	__Ulcers
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction	__Coughing Blood
__Seizures/Convulsions	__Strokes	__HIV Positive	__High/Low Blood Pressure
__A Congenital Disease	__Cancer	__Gall Bladder	
__Excessive Bleeding	__Ruptures	__Depression	

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? π Yes π No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Please list any other health problems you have, no matter how insignificant they may be:_____

_____

Have you had chiropractic treatment previously? ___Yes___No If yes, for what_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?___ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list:_____
Please indicate if you are interested in our clinical nutrition program and would like to be evaluated to see what vitamins and supplements may be right for you. _____Interested _____ Not Interested
Do you consume caffeine?____ If so, how much per day:_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting_____ sitting_____ bending_____working at a computer_____

FAMILY HISTORY:

Father: living___ deceased____ Current age if still living:_____
Cause of death and age at death if deceased:_____
Mother: living___ deceased____ Current age if still living:_____
Cause of death and age at death if deceased:_____
Do you have any family members who suffer from the same condition you do? If so, please list:_____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis____	Cancer____	Mental Illness____
Diabetes ____	Asthma____	Heart Disease ____
Stroke ____	Kidney Disease____	Lung Disease____
Arthritis_____	Liver Disease ____	Other_____

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to Kominsky Chiropractic gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of our doctors. The Chiropractic Physician provides a specialized, non-duplicating health care service. We are licensed in a special practice and available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Kominsky Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature: _____ Date: _____

Name:_____Date:_____

Low Back Pain – Choose Only 1 Answer in each section

SECTION 1--Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain is severe but comes and goes.
- The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)

- I can look after myself without causing extra pain.
- I can look after myself normally but it causes some extra pain.
- It is painful to look after myself but I manage not to change my way of doing it.
- Washing and dressing do increase the pain enough that I have to change my way of doing it.
- Because of the pain, I am unable to do **some** washing or dressing without help.
- Because of the pain, I am unable to do **any** washing or dressing without help.

SECTION 3--Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

SECTION 4 --Walking

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk for more than ½ mile without increasing pain.
- I cannot walk more than ¼ mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5--Sitting

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain right away.

SECTION 6 – Standing

- I can stand as long as I want without pain.
- I have some pain on standing, but it does not increase with time.
- I cannot stand for more than 1 hour without increasing the pain.
- I cannot stand for more than ½ hour without increasing the pain.
- I cannot stand for longer than 10 minutes without increasing the pain.
- I avoid standing because it increases the pain right away.

SECTION 7--Sleeping

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain my normal nights sleep is reduced by less than ¼.
- Because of pain my normal nights sleep is reduced by less than ½.
- Because of pain my normal nights sleep is reduced by less than ¾.
- Pain prevents me from sleeping at all.

SECTION 8—Social Life

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

SECTION 9--Traveling

- I get no pain while traveling
- I get some pain while traveling, but none of my usual forms of travel make it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling, which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

SECTION 10—Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but is definitively getting better.
- My pain seems to be getting better, but is definitively slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Name:_____Date:_____

Neck Pain – Choose ONLY 1 Answer for each section

SECTION 1--Pain Intensity

- I have no pain at the moment
- The pain is mild at the moment.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain is severe but comes and goes.
- The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)

- I can look after myself without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help, but manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 4 --Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I cannot read as much as I want because of moderate pain in my neck.
- I cannot read as much as I want because of severe pain in my neck.
- I cannot read at all.

SECTION 5--Headache

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come in-frequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

SECTION 6 – Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

SECTION 7--Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

SECTION 8--Driving

- I can drive my car without neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive my car at all because of severe pain in my neck.
- I cannot drive my car at all.

SECTION 9--Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1-2 hours sleepless).
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation

- I am able engage in all recreational activities with no pain in my neck at all.
- I am able engage in all recreational activities with some pain in my neck.
- I am able engage in most, but not all recreational activities because of pain in my neck.
- I am able engage in a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I cannot do any recreational activities all.

SYMPTOM INTENSITY AND FREQUENCY

Name:_____ Date:_____

CURRENT PAIN INTENSITY LEVELS

Describe on a scale of 1-10 how intense your pain or symptoms are. This includes the amount of aching, soreness, hurting, pain, numbness, and/or tingling levels present currently. A zero (0) indicates that no symptoms exists. **1-3 pain** level is a minimum level and indicates that your pain is an annoyance only. A **4 pain** is a slight level, where pain doing activity begins to cause some disability. A **5-7 pain** is moderate in severity and has to restrict or limit your activity ability to a significant degree. A **8-10 pain** level is severe and indicates that your pain intensity is to point where you have complete inability to perform some tasks.

Circle the box that best describes your symptoms today

Pain Intensity	None	**MINIMAL** Discomfort/Ache/Stiff		**SLIGHT-TO-MODERATE** Hurts/Sore/Bearable Sensation				**SEVERE** Sharp/Intense Pain		
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck Pain/Soreness	0	1	2	3	4	5	6	7	8	9	10
Arm/Hand Symptoms	0	1	2	3	4	5	6	7	8	9	10
Mid Back Pain	0	1	2	3	4	5	6	7	8	9	10
Low back Pain	0	1	2	3	4	5	6	7	8	9	10
Leg/Foot Symptoms	0	1	2	3	4	5	6	7	8	9	10
Other_____	0	1	2	3	4	5	6	7	8	9	10

CURRENT PAIN FREQUENCY LEVELS

Describe how frequent you have symptoms such as pain, numbness, and tingling in the respected areas. A zero (0) indicates that no symptoms exists. **1-3 frequency** level is a minimum level and indicates that your symptoms are occasional. A **4 –6 frequency** is a moderate level, meaning that symptoms are intermittent, coming and going. A **7-8 frequency** is an indication that the symptoms are present more often than not but still not constant. A 9**-10 frequency** level is severe and indicates that your symptoms are constant.

Circle the box that represents the average percentage of time you have symptoms

Pain Frequency	None	Occasional		Intermittent			Frequent		Constant	
Neck pain/soreness	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm/Hand Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid-back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low Back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/Foot Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

CURRENT HEADACHE FREQUENCY & DURATION

A. How frequently do you have headaches/migraines currently?	☐ No headaches ☐ once a month ☐ twice a month	☐ once a week ☐ twice a week ☐ 3 times a week	☐ 4 times a week ☐ 5 times a week ☐ Almost daily
B. How long does your typical migraine last?	_____Hours _____Days		

Authorization for the Release of Medical Records

Patient Name:_____Date of Birth:_____
(also list maiden name/other names used)

I hereby request and authorize:

Kominsky Chiropractic
3157 Robert C. Byrd Dr.
Beckley, WV 25801

Phone: (304) 253-3489
Fax: (304) 253-3148

_____To Disclose information to: _____To Receive Information from:

Provider:_____

Information to be disclosed include copies of:

_____Entire Record
_____Progress Notes
_____Physical Exam forms
_____Daily chart notes
_____X-ray Reports
_____X-ray Films
_____Other, specify:
_____

Purpose for disclosure:

_____ Treatment, Payment OR _____ Other (Specify)_____

This authorization will be effective for six months after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

_____Date:_____
Signature of Patient

OR

_____Date:_____
Signature of Legal Representative/Relationship

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Date