Keels Chiropractic

3409 Boiling Springs Rd.

Family*Sports*Nutrition
www.keelschiro.com

Boiling Springs SC 29316
(864) 599-8883

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:	**Date:**
Address: Street City State Zip	
Home phone:	**Work phone:**
Cell phone:	**Email address:**
Best time/place/way to contact you:	
Date of birth:	**Age:**
No. of children:	**Pregnant? Yes ☐ No ☐**
Height:	**Weight:**
Social Security Number:	
Marital status: M S W D	**Spouse/guardian name:**
Occupation:	
Employer's name & address:	
Spouse's Occupation/Employer:	
Name of person responsible for account:	
Do you have insurance that covers Chiropractic care? **Yes ☐ No ☐ Unsure ☐**	**Do you have Medicare/Medicaid coverage?** **Yes ☐ No ☐**
Name of Insurance Company:	
Insurance Policy number:	**Insurance Company phone number:**
Insurance Company address:	

Who may we thank for referring you? ______________________________

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for **Chiropractic Wellness Services**, please skip to the **General Health History.**

If you need more room than what is given for any section, please write on the back.

Health Concerns

Please list your health concerns according to their severity. Please answer the questions that follow thinking of your primary complaint.	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start? (approximately)	Have you had this condition before? When?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					

Is your pain dull? Or is your pain sharp? Does it travel anywhere? If so, where?

____

____

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

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What have you done for this condition? Did it help?

____

____

Do you have a family history of this or similar symptoms (Please explain):

____

____

Which activities aggravate your condition?

____

____

Other Doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	☐
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	☐
Medical Doctor	☐
Dentist	☐
Other (please describe)	☐

Doctors Details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Is this condition interfering with any of the following:

Work ☐	Sleep ☐	Daily routine ☐	Sports/exercise ☐	Other ☐ (please explain):

Other____

____

___

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery,)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

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Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Current Medicines

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

____
____

Current Supplements

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

____
____

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well being?	Yes ☐ No ☐ Maybe ☐
If dietary changes are indicated would you be willing to make changes in your diet?	Yes ☐ No ☐ Maybe ☐
If specific exercises, stretching or yoga would help would you consider adding them to your program?	Yes ☐ No ☐ Maybe ☐
If reducing stress would you help you would you like to know ways to reduce stress?	Yes ☐ No ☐ Maybe ☐

Diet(Optional)

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day **| W** - Consume this weekly | **FW** - Consume this a few times per week
FM - Consume a few times per month (less than weekly) **| M -** Consume this monthly **| O -** Do not consume this

Alcohol	Artificial Sweeteners	Diet food/drinks	Tobacco
Coffee/Hot Tea	Sweet Tea	Refined Sugar	Table Salt
Fresh Fruit	Fresh Vegetables	Processed Foods	Soda/Juice
Fried Foods	Local Foods	Organic Foods	Water(how much)__________oz
Breakfast	Lunch	Dinner	Between meal snacks
How many meals a week do you eat that are homemade?______		How many meals a week do you eat out?________	

The type of diet I usually follow is classified as: ____

Past Health History

Please mark the following conditions you may have had or have now (please check or X appropriate box.):

☐ Alcoholism	☐ Allergy	☐ Anemia	☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Cancer	☐ Cold Sores	☐ Constipation	☐ Convulsions	☐ Depression
☐ Diabetes	☐ Diarrhea	☐ Eczema	☐ Emphysema	☐ Epilepsy	☐ Gall Bladder Problems
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ High Blood Pressure	☐ HIV (Aids)
☐ Irregular Periods	☐ Low Blood Sugar	☐ Malaria	☐ Measles	☐ Menstrual Cramps	☐ Migraines
☐ Miscarriage	☐Multiple Sclerosis	☐Mumps	☐ Neck Pain	☐ Nervousness	☐ Neuritis

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☐ Pleurisy	☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Ringing in ears	☐Sinus Problems
☐ Stroke	☐ Thyroid Problems	☐Tuberculosis	☐ Ulcers	☐ Venereal Disease	☐ Whooping Cough
☐ Dizzy	☐ Ear Infections	☐ Insomnia	☐ Fatigue	☐ Sore Throat/ Hoarse	☐ Chronic Cough
☐ Nausea	☐ IBS/Crohns	☐ Bladder Problems	☐ Infertility	☐ Restless Leg Syndrome	☐ Shortness of Breath

Other (please explain)

____

____

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work, posture, etc.)
   a. ____
   b. ____
   c. ____

2. Chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. ____
   b. ____
   c. ____

3. Mental/Emotional stress (work, relationships, finances, self-esteem, etc.)
   a. ____
   b. ____
   c. ____

How much time do you spend in front of a computer? ________Hrs Day/Wk None

On a scale of 1-10 please grade your present levels of stress

At work:	At home:	At play:

How do you grade your physical health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

How do you grade your emotional/mental health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

Is there anything else which may help to better understand you or your condition that has not been discussed?

____

____

Why did you decide to pursue chiropractic care for your conditions?

____

____

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Consent to Chiropractic Care

The objective of chiropractic is to remove a type of nerve interference that can occur from time to time in the human being known as vertebral subluxation.

Subluxations are small misalignments of the vertebrae that make up the human spine. These misalignments can cause a disturbance to nerve function which in turn causes malfunction to the transmission of nerve impulses. This often presents a problem for the body to be able to maintain health naturally.

A chiropractic adjustment is a specific manual force (done by hand) which helps the body to bring about a correction of the vertebral subluxation. Our professional goal is to correct vertebral subluxations by making specific adjustments to the spine when such conditions are detected during a chiropractic examination.

We do not treat specific diseases, as this is not our professional objective. If you (the patient) would like to consult a practitioner that specializes in the diagnosis or treatment of a specific ailment we recommend that you make an appointment with such a specialist.

By placing your signature on this form you acknowledge that you understand the objective of chiropractic and agree to accept chiropractic care at this office based on this practice objective.

Payment Acknowledgement

It is usual and customary to pay for services as rendered unless otherwise arranged in writing.

I (the patient) do hereby authorize Keels Chiropractic to furnish my insurance company with a full report of physical examination, diagnosis, treatment, prognosis, and etc. of myself in regard to my injury, if requested by them.

I hereby authorize and direct payment directly to said doctor such sums as may be due on owing him for chiropractic services rendered me. I understand I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for service rendered to me. This agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment.

I have read and agree to be bound by the terms of this assignment of benefits. I have also been advised that if my insurance company does not cooperate in protecting said doctor's interest, he will not await payment but may declare the entire balance due and payable. These assigned proceeds shall not exceed amounts due and payable to said doctor for services rendered.

Privacy Notice Acknowledgement

Our office is very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you (the patient) with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I (the patient) acknowledge that I have received or declined a copy of Abner Creek Chiropractic's *Privacy Notice* and agree to its terms. I have also read your consent policy and agree to its terms.

_______________________________ **Patient's Name (Printed)**

_______________________________ **Date**

_______________________________ **Patient's Signature**

_______________________________ **Guardian's Signature**