DAVID L. MARTIN D.C.
KYLE R. CARPENTER B.S., D.C.

MARTIN CHIROPRACTIC

KINETIC SPORTS MEDICINE

OUT-OF-POCKET

PATIENT INFORMATION: TODAY'S DATE: _____

FULL NAME: _____ SS#: _____

HOME ADDRESS: _____ (UNIT/SUITE/APT#): _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL ADDRESS: _____

CELL PHONE#: _____ SEX: M_____ F_____

DATE OF BIRTH: _____ AGE:_____ HEIGHT: _____ WEIGHT: _____

PRIMARY PHYSICIAN (NAME, ADDRESS, PHONE NUMBER): _____

_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PATIENT EMPLOYMENT INFORMATION

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: _____

SPOUSE/EMERGENCY CONTACT

MARITAL STATUS: M_____ S_____ W_____ D_____ NO. OF CHILDREN: _____

SPOUSE'S NAME: _____

SPOUSE'S DOB: _____ SPOUSE'S PHONE#:_____

EMERGENCY CONTACT (NAME & PHONE NUMBER):

_____

PATIENT FAMILY MEDICAL HISTORY:

Please check off if anyone in your family has had problems with:

___Diabetes, Thyroid, or other

___Endocrine Disorders

___Hypertension

___Lipid Disorders

___Cardiovascular Disease

___Prostate Disease

___Cancer

___Other Illness not noted

PATIENT MEDICAL HISTORY:

Please check off if you have a history or early finding of the following:

___Pregnant/Lactating

___Blood Disorders

___Cancer

___Immune Disorders

___Poor wound healing

___Edema/excess fluid retention

___High Cholesterol

___Upper respiratory problems

___Lung Disorder

___High Blood Pressure

___Renal Disease

___Heart Attack

___Emotional Disorders

___Genital-Urinary Disorder

___Glaucoma

___Carpal Tunnel Syndrome

___Surgery

___Drug Allergies

___Chemical Dependency

___Food Allergies

If you checked off any item above, please explain: _____

_____

Do you get regular exercise? _____ If yes, what type frequency, duration, & where?_____

Please list any medications used in the past 12 months?_____

_____

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CONFIDENTIAL HEALTH QUESTIONNAIRE

NAME: _____ AGE: _____ DATE: _____

CHECK CONDITIONS THAT APPLY:

GENERAL

___ALLERGY
___FATIGUE
___CONSTIPATION
___DIARRHEA
___NAUSEA
___VOMITTING
___DIZZINESS
___PAINFUL BREATHING
___ASTHMA
___HIGH/LOW BLOOD PRESSURE
___FREQUENT URINATION
___PAINFUL URINATION
___PROSTATE TROUBLE

MUSCLE/JOINTS

___HEADACHES
___NECKPAIN/STIFFNESS
___SHOULDER PAIN
___ARM PAIN, NUMB
___ELBOW PAIN
___WRIST/HAND PAIN
___MID BACK PAIN
___LOW BACK PAIN
___HIP PAIN
___SCIATICA
___KNEE PAIN
___LEG PAIN/NUMBNESS
___FOOT/ANKLE PAIN/NUMBNESS

REASON FOR VISIT: _____

HOW LONG HAVE YOU HAD THIS CONDITION? _____

GETTING WORSE OR BETTER? _____ INITIAL CAUSE OF PAIN? _____

DO YOU HAVE PAIN DURING ___AM ___PM ___WORK ___HOME

___SLEEP ___RISING ___ACTIVITY

AGREEMENT STATEMENT:

I clearly understand and agree that all services rendered to me are charged to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

PATIENT'S SIGNATURE: _____
(If patient is a minor, parent or guardian's signature is required)

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KYLE R. CARPENTER B.S., D.C.

ACKNOWLEDGEMENT OF "NOTICE OF PRIVACY PRACTICE"

PRINT NAME: _____ DATE: _____

PATIENT'S SIGNATURE: _____
(If patient is a minor, parent or guardian's signature is required)

- The HIPPA Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. If you would like a copy of this notice, please let us know.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT OF YOUR PAIN

The nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment he/she determines is most appropriate for your condition.
Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.
Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer, and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. *Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and other medical conditions you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.*
Other options for treatment of pain include: *Do nothing, live with it, over the counter medications, physical therapy, medical care, injections, or surgery.* There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment: _____

My signature below confirms that I have read the paragraphs above and that I understand the possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused me pain in the past.

PATIENT SIGNATURE: _____ DATE: _____