# New Patient Information

| | |
|---|---|
| Name: | Date: |
| Address: | City: |
| State: | Zip code: |
| Date of Birth: | Sex: M F Other |
| Social Security Number | |
| Spouses Name | Spouses D.O.B. |
| How did you hear about us? | |

An appointment reminder will be sent electronically to your cell phone or email. If you would like to receive text message, please enter your phone number and the name of your phone carrier (I.E. AT&T, Sprint, Etc.)

| | |
|---|---|
| Home Phone | Cell Phone |
| Phone Carrier | Email |

Appointment reminders and private health information will be communicated to you only in manners in which you have given specific written authorization and you have the option to opt out of any of those methods at any time by notifying our office. Email and standard text messaging are not confidential methods of communication and may be insecure.

I authorize Kentucky Family Chiropractic to text or email a reminder of my upcoming appointment(s). _____ (Please Initial)

There is a posted copy of the Hippa guidelines at the front desk and will be provided for me as needed. Should I have any questions or require any changes to be made to my records, I will contact Janene Jones, designated privacy official. I acknowledge receipt of a copy of the office "Notice of Patient privacy Policy. _____ (Please Initial)

I certify that I, and/or my dependent(s) have insurance coverage with _____ (Name of Insurance) and assign directly to Dr. Cole all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance, I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

| |
|---|
| Are you pregnant? Yes_____ No_____ |



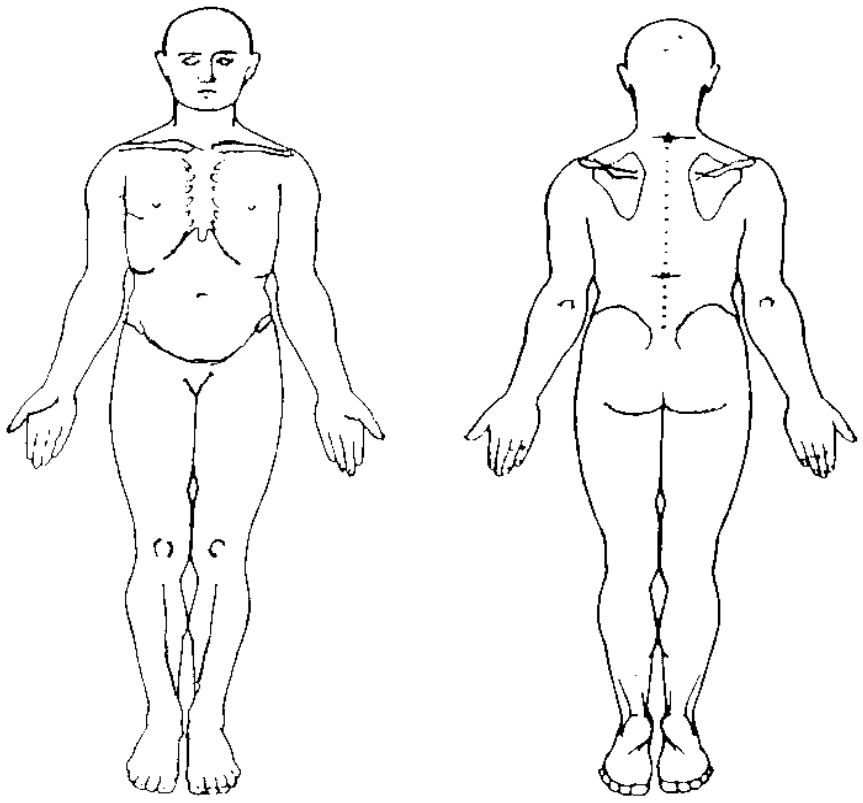
Kentucky Family Chiropractic
30 Stonecrest Court Suite 102
Shelbyville, Ky. 40065

| Name: | Date: |
|---|---|

| Reason for visit? |
|---|
| How often does the pain occur? |
| Description of pain? Sharp___ Dull___ Throbbing ___ Numbness ___ Aching ___<br>Shooting ___ Stiffness ___ Tingling ___ Burning ___ Stinging ___ |

| When did your symptoms appear? |
|---|
| What activities are you having trouble performing due to pain? |
| Have you noticed anything that makes the pain feel better? |
| Rate your pain from 1 (mild) to 10 (severe) when occurring. |
| Have you noticed any changes in bowel or bladder function? |
| Who is your primary care physician? |

Please mark an X on the picture where you continue to have pain, tingling, and/or numbness.





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| Name: | Date: |
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What PREVIOUS TREATMENTS have you tried for this condition?

___None ___Physical Therapy ___Chiropractic ___Surgery ___Epidurals ___Pain Medication
___Over the Counter Anti-Inflammatory ___Prescription Anti-Inflammatory

Have you had any MRI, CT scans or X-Rays taken recently? Yes ___ No ___

If so, when and where?

HEALTH HISTORY: Have you ever had any of the following conditions?

| | | |
|---|---|---|
| ___Multiple Sclerosis | ___Pacemaker | ___Gout |
| ___Neuropathy | ___Stroke | ___ **Anemia** |
| ___Parkinson's | ___Aneurysm | ___Spine Surgery |
| ___Epilepsy | ___Kidney Disease | ___ Osteoporosis |
| ___Thyroid Dysfunction | ___Asthma | ___ Rheumatoid Arthritis |
| ___Heart Disease | ___COPD | ___ Cancer |
| ___Sleep Apnea | ___Emphysema | ___ Depression |
| ___High Cholesterol | ___Acid Reflux | ___ Bipolar |
| ___High Blood Pressure | ___Diabetes | ___ Psoriasis |

Please list all previous surgeries:

Please list any previous fractures :



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|---|---|

FAMILY HISTORY: Please place a check in the appropriate box if your family member has had any of the following conditions.

| | Mother | Father |
|---|---|---|
| Cancer | | |
| Diabetes | | |
| Heart Condition | | |
| Stroke | | |
| High Blood Pressure | | |
| Lupus | | |
| Rheumatoid Arthritis | | |
| Osteoarthritis | | |
| Thyroid | | |
| Multiple Sclerosis | | |

| |
|---|
| Occupation: Full Time ___ Part Time ___ Retired ___ Unemployed ___ Disabled ___ |
| Marital Status: Married ___ Widowed ___ Single___ Minor ___ Divorced ___ |
| Smoking: Current Smoker ___ Previous Smoker ___ Occasional Smoker ___ Non-Smoker ___ |
| Exercise: None ___ Daily _____ Moderate ___ |

Are you right or left hand dominant? _____

Medication List:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies:

_____
_____
_____
_____
_____
_____
_____
_____
_____



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| Name: | Date: |
|---|---|

This is in, regards to your personal health information. If there is someone that you would like to grant access to your private health information, please put their name in the blank provided below.

I give Kentucky Family Chiropractic permission to release or obtain any information pertaining to my care/appointment to _____. I also give Kentucky Family Chiropractic permission to obtain previous medical records pertaining to my medical care.

I request consent to the performance of chiropractic, examination, adjustment/manipulation and all other chiropractic procedures permitted by our state law, including medical records review, various modes of physiotherapy and necessary diagnostic x-rays on myself (or on the patient names below, for whom I am legally responsible) by any of the treating Doctor of Chiropractic on staff and/or any licensed chiropractor deemed appropriate by the office. I understand that results of treatment are not guaranteed. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are risks associated with treatment, although rare, including but not limited to, fracture, disc injuries, strokes, dislocations, strains, and worsening symptoms. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. This consent form covers the entire course of treatment for my present condition(s) for which I seek treatment.

**I understand it is my responsibility to fill out my case history completely and to the best of my knowledge, and to inform the doctor of any information that is not listed on my case history. I also understand that it is my responsibility to inform the doctor of any changes that may occur once I have filled out that information. I authorize Dr. Diana Cole, DC to treat me.**

**I have read and understood the foregoing.**

Signature: _____ Date: _____



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