

When was the first time you were aware of this problem? _____

Have you ever had this problem or similiar problem before? _____

If yes, please explain: _____

Have you ever received any treatment for this condition? _____

If yes, where and when, and what were your results? _____

Has this problem been getting better, worse or staying the same? _____

Is there anything you do that makes your condition worse? _____

Have you ever been in an automobile accident? Past Year Past 5 Years Over 5 Years Never

Any accidents, falls, etc. that might have caused your problem _____

Have you had any surgeries? If yes, please list: _____

Are you pregnant? Yes No

Please check if you have any of the following: vascular disease metal implants diabetes

pacemaker malignancy

Please list medications and dosage: _____

Any chiropractor consulted in the past? Name _____

Dates consulted: _____

For what condition: _____

Fees are payable at the time x-rays, examinations and treatments are received, unless other arrangements are made in advance. X-rays remain the property of this clinic.

Patient's Signature: _____ Date: _____

(Confidential)

Patient Name _____ Today's Date _____

Age _____ Birth date _____ Date of last physical examination _____

What is your reason for visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

MUSCLE / JOINT / BONE

- Pain, weakness, numbness in:
- Arms Hips
 - Back Legs
 - Feet Neck
 - Hands Shoulders

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

GASTROINTESTINAL

- Appetite Poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sin us problems
- Vision - Flashes
- Vision -Halos

SKIN

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

MEN Only

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other _____

WOMEN Only

- Abnormal Pap Smear
 - Bleeding between periods
 - Breast lump
 - Extreme menstrual pain
 - Hot flashes
 - Nipple discharge
 - Painful intercourse
 - Vaginal discharge
 - Other _____
- Date of last menstrual period _____
 Date of last Pap Smear _____
 Have you had a mammogram? _____
 Are you pregnant? _____
 Number of children _____

Conditions

Check (✓) symptoms you currently have or have had in the past year

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal Disease |

Medications

List medications you are currently taking

Allergies

Pharmacy Name _____ Phone _____

Health History

Family History

Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your blood relatives had any of the following:	
					Disease	Relationship to you.
Father					Arthritis	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization & Outcome

Have you ever had a blood transfusion? Yes No
 If yes, please give approximate dates _____

Serious Illness / Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to the following:

	Stress	Hazardous Substances
	Heavy Lifting	Other
Occupation _____		

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his / her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature

Reviewed By

Date

Date

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

Patient's Name (Print)

X _____
Patient's Signature

Date

Relationship or authority if not signed
By patient

Witness

AUTHORIZATION AND ASSIGNMENT

TO: West Knox Chiropractic Group

In consideration of your undertaking to treat me, I agree to the following:

Authorization to Release Information

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

Assignment of Cause of Action

In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is/are believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due), I personally owe you, and agree to pay in a current manner.

Authorization to Pay Directly to Doctor

TO: _____

(Name of attorney and/or insurance company)

In consideration of the chiropractic services rendered and to be rendered by him, I authorize and direct the payment to the doctor named above of any sum I now or hereafter owe him by you, my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for his services or otherwise obligated to reimburse me for the charges for his services or otherwise obligated to make payment to me or him based in whole or in part upon the charges made for his services.

Acknowledgement and Understanding

I hereby acknowledge that I am receiving (or about to receive) health care services at West Knox Chiropractic Group, and that I have been advised that the doctor(s) providing the services is/are willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that if it is determined either:

- (a) That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor(s) or make other provisions for the protection of the interest of the doctor(s); or
- (b) If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor(s), or if I have not engaged the services of an attorney;

then payment for services rendered by the doctor(s) at West Knox Chiropractic Group will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

Dated the _____ day of _____, 20____.

X _____
(Patient's Signature)

(Witness)

CHIROPRACTIC TREATMENT AND PROTOCOL

1. **MANIPULATION** – Gentle passive force to encourage normal joint mechanics and break up scar tissue adhesions in ligaments. Therefore, aligning the joints into proper position to encourage function, increase blood flow and release neurologic impingements.
2. **TRACTION/MOBILIZATION/TRIGGER POINT** – These treatments are used in conjunction or separately to the manipulation. These include long axis traction to decrease intradiscal pressures and break up scar tissue adhesions. Trigger point therapy breaks the spasm cycle of the muscles by restimulating, contracting, and/or relaxing muscles at the tendon enthesis (attachment point). This is generally the stretching and mobilization used by the doctor prior to the manipulation. By loosening the joints, it allows for a smoother and more effective manipulation.
3. **MUSCLE STIMULATION** – This is a procedure used to passively exercise muscular soft tissue up to tolerance of healthy tissue, but not past the point of pain where tissue destruction could take place. The electrical current stimulates the nerves as they enter the muscle and gently contracts the muscle in a rhythmic pattern to accomplish a variety of therapeutic benefits. At the time of injury, muscles, ligaments, and paravertebral soft tissue (known as mesenchymal connective tissue) are flooded with lactic acid and toxic materials. These toxic materials must be cleansed by the lymphatic system. Unlike the “blood” system which has a heart to pump it, the lymphatic system relies upon the movement of the surrounding tissues to push it through. While this natural movement can be severely restricted by pain and swelling, it can be instigated with electrical muscle stimulation which contracts the muscles in rhythmic patterns which aid greatly in assisting the body in this cleansing process. Because inactivity allows a muscle to heal in a weakened state, muscle stimulation is an excellent procedure because it promotes healing, strengthening, reduces spasms, and increases circulation in the recuperating muscle.
4. **ULTRASOUND** – Ultrasound is high frequency sound waves which penetrate the tissue and the sound causes a vibration within the tissue i.e. “micro massage”. Microscopic massage is the vibration of each individual cell which causes the cell to greatly increase its metabolic rate or throw off its waste products. This is very helpful because injured or malfunctioning tissue can not metabolize or throw off its waste products due to congestion, which can cause a weakened state, malfunction, scar tissue, or calcification. Mechanical vibration of the cells is accomplished because of the high frequency of the ultrasound waves causing the molecules and the tissue cells to “rub” against each other. The friction of the movement of cells creates heat in the tissues which in turn increases the circulation in the immediate area. The increased circulation means that nutrition is being brought in to the area for healing and waste matter is being removed.
5. **ULTRASOUND/MUSCLE STIMULATION COMBINATION** – Combines the above characteristics of 3 and 4 into dual therapy, thereby delivering all the therapeutic benefits at the same time.
6. **INTERFERENTIAL ELECTRO- THERAPY** – Interferential Electro-Therapy is a proven therapeutic treatment for the relief of pain and the promotion of soft tissue healing. Tiny amounts of electrical impulses are induced into the tissues in the vicinity of the injury. At the point where these waves intersect below the surface of the skin, low frequency stimulation is created. This prompts the body to secrete endorphins and the body’s other natural painkillers to help relieve pain. Interferential Electro-Therapy reduces painful symptoms, decreases local swelling, promotes muscle tone, helps restore normal movements, and accelerates the healing process.
7. **MOIST HEAT** – This therapy can be used to help long term healing as it softens the tissue and promotes pliability as the tissue heals. Hot packs have several therapeutic benefits. Moist heat expands the openings of blood vessels to promote increased blood flow, thereby increasing nourishment of injured tissue. It relaxes muscles thereby reducing the spasms; even at the lower tissue levels which slows pulse rate respiration. Hot packs also slow down reactions to muscle spasms and calms the unwanted response to nerve excitability that bring “stabbing pains” during muscle spasms, and dilates channels in your body to help get rid of waste products and make room for new tissue growth. **PLEASE – NO HEAT ON RECENT INJURY!**
8. **CRYOTHERAPY (ICE PACKS)** – Ice is used most often for the calming of irritated nerve roots or for decreasing the inflammation of a “hot” spinal disc or joint. Ice is incorporated many times in new injuries or conditions in what is known as the “acute stage” or when an exacerbation of an old injury occurs. Ice brings on relief by constricting blood vessels in the involved area and thereby decreases the swelling and pressure which ultimately reduces the pain. This constriction of the blood vessels decreases the possibility of internal bleeding occurring in the muscles, ligaments, and surrounding tissues which appear as a bruise.
9. **TRACTION (SPINALATOR)** – Motorized intermittent traction places a gentle stretch on the spine to separate the vertebrae and relieve direct nerve pressure. It also takes the stress of the discs between the vertebrae. This stretching effect of the disc creates suction and lets the disc absorb more blood and healing nutrients, thus allowing it to heal more quickly. Traction reduces adhesions, mobilizes joints, restores ligament elasticity, reduces hydrostatic pressure, and strengthens area of involvement.
10. **TRACTION MECHANICAL** – Utilizes computerized technology to slowly stretch either the cervical or lumbar spine to decrease intradiscal or intra-joint pressure. By relieving this pressure it creates a gravity negative effect allowing for possible retraction of expanded joint materials therefore relieving painful pressures and also incorporates all benefits of 9.

ALWAYS, IF YOU HAVE QUESTIONS, PLEASE ASK THE DOCTOR OF STAFF. THANKS.

I have read and consent to the above treatments: _____ Date _____
Patient's Signature



WEST KNOX CHIROPRACTIC GROUP

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DR. ALAN C. LENSGRAF, CLINIC DIRECTOR
DR. DANIEL R. KOELSCH

WEST KNOX CHIROPRACTIC GROUP HIPAA COMPLIANCE FORM

I, _____ have received a copy of West Knox Chiropractic Group's Notice of Patient Privacy Practices.

I hereby authorize the use of disclosure of my individually identifiable health information (records of treatment to be released to primary care physician and when requested by insurance company). I understand that this authorization is voluntary.

I hereby give my consent for West Knox Chiropractic Group to use and disclose protected health information about me to carry out treatment, payment and healthcare operation. With this consent, West Knox Chiropractic may call my home or other alternative location and leave a message on voice mail. With this consent, West Knox Chiropractic Group may mail to my home or other alternative location appointment reminder cards, birthday cards, recall postcards, letters, patient statements, etc.

Signature of Patient or Legal Guardian

Date