New Practice Member Forms

KEYSTONE CHIROPRACTIC

Name: ____ Date: ____________________

Age: _________ ☐ Male ☐ Female SSN: ____________________________ Birthday: _________________

Address: ____

City: _______________________________________ State: ______________ Zip: ________________________

Home phone: ____________________________________ Cell phone: __________________________________

Cell Phone Provider: ☐ Verizon ☐ AT&T ☐ T-Mobile ☐ Sprint ☐ Other: ___________________________

E-mail: ____

Occupation: ____

Employer's Name: ____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: _______________________________________ # of Children: __________

Child's Name: _____________________________________ Age: ______

Child's Name: _____________________________________ Age: ______

Child's Name: _____________________________________ Age: ______

Child's Name: _____________________________________ Age: ______

Child's Name: _____________________________________ Age: ______

Child's Name: _____________________________________ Age: ______

In Case of Emergency: ____ Phone #: _____________________

How did you hear about Keystone Chiropractic? ____

Who may we thank for referring you? ____

Check All Current Problems You Have:

☐ Headaches	☐ Asthma	☐ Heart disorder	☐ TMJ pain	☐ Shoulder pain
☐ Migraines	☐ High blood pressure	☐ Stomach disorder	☐ Neck pain	☐ Hip pain
☐ Dizziness	☐ Chronic fatigue	☐ Gastric reflux	☐ Numbness in arms	☐ Leg pain
☐ Vertigo	☐ Chest pain	☐ Ulcers	☐ Numbness in hands	☐ Knee pain
☐ Nausea	☐ Nervousness	☐ Irritable bowel	☐ Mid back pain	☐ Arm pain
☐ Anxiety	☐ ADD/ADHD	☐ Constipation	☐ Low back pain	☐ Kidney problem
☐ Allergies	☐ Sinus problems	☐ Diarrhea	☐ Numbness in legs	☐ Thyroid problem
☐ Infertility	☐ Loss of energy	☐ Sleeping issues	☐ Numbness in feet	☐ Liver disease
☐ Depression	☐ Throat issues	☐ Bladder problems	☐ Sciatica	☐ Fibromyalgia
☐ Ear infections	☐ Epilepsy	☐ Menstrual issues	☐ Carpal tunnel	☐ _________________

Have you ever seen other doctors for these conditions? ☐ Yes ☐ No

If yes: ☐ Chiropractor ☐ Medical Doctor ☐ Other ____________________________

Who & When: ____

Name of Primary Care Physician: ____

Check Any Conditions You Have Now/Have Had:

☐ Stroke	☐ Cancer	☐ Heart Disease	☐ Spinal Surgery
☐ Scoliosis	☐ Diabetes	☐ Seizures	☐ Spinal Bone Fracture

List all surgical operations & years: ____

____

List all over-the-counter & prescription medications you are on, and the reason for each: __________________

____

____

____

Were you ever in a car accident? If so, when? ____

Have you even been knocked unconscious? ☐ Yes ☐ No Please describe: _____________________________

Other trauma: ____

History of Health Concerns

Please start at the top of your body and work your way down.

Symptom 1: ____

- On a scale of 1 – 10, 10 being the worst pain you've ever felt, what is the severity of your symptom?
  1 2 3 4 5 6 7 8 9 10
- What percent of the time do you feel the symptom?
- 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- When did this episode begin? ______________________
- Did it begin: ☐ Suddenly ☐ Gradually
- Describe how it began: __________________________
- Have you had the symptom in the past? ☐ Yes ☐ No
- If yes, when was the first time you've ever felt the symptom: ______________________________________
- What makes the symptom worse?
- ____
- What makes the symptom better?

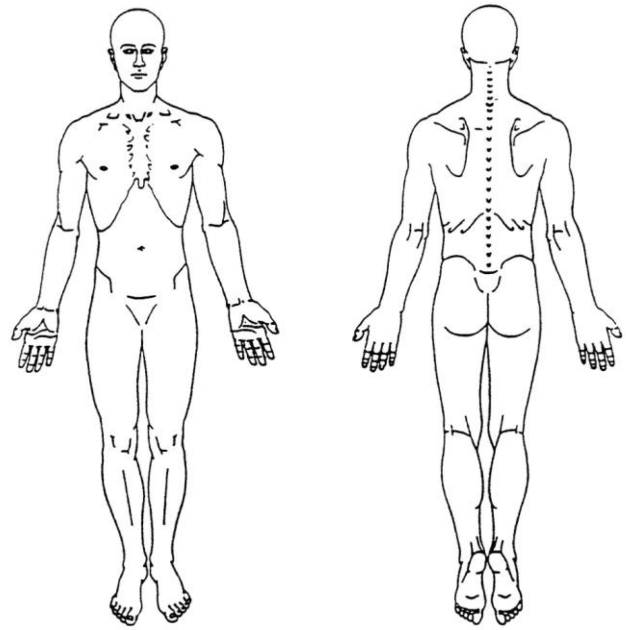
____

Does the pain radiate? ☐ Yes ☐ No

- If yes, describe in detail where it radiates: ____________
- Does the pain feel worse at a particular time of day?
  ☐ Morning ☐ Afternoon ☐ Early evening ☐ Late at night
  ☐ Unchanged by time of day

Please mark on the diagram with the following letters to describe your symptoms:

R=Radiating **B**= Burning **D**=Dull **A**=Aching
S=Sharp/Shooting **T**=Tingling **N**=Numbness



Symptom 2: ____

- On a scale of 1 – 10, 10 being the worst pain you've ever felt, what is the severity of your symptom?
  1 2 3 4 5 6 7 8 9 10
- What percent of the time do you feel the symptom?
- 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- When did this episode begin? ______________________
- Did it begin: ☐ Suddenly ☐ Gradually
- Describe how it began: __________________________
- Have you had the symptom in the past? ☐ Yes ☐ No
- If yes, when was the first time you've ever felt the symptom: ______________________________________
- What makes the symptom worse?
- ____
- What makes the symptom better?

____

Does the pain radiate? ☐ Yes ☐ No

- If yes, describe in detail where it radiates: ____________
- Does the pain feel worse at a particular time of day?
  ☐ Morning ☐ Afternoon ☐ Early evening ☐ Late at night
  ☐ Unchanged by time of day

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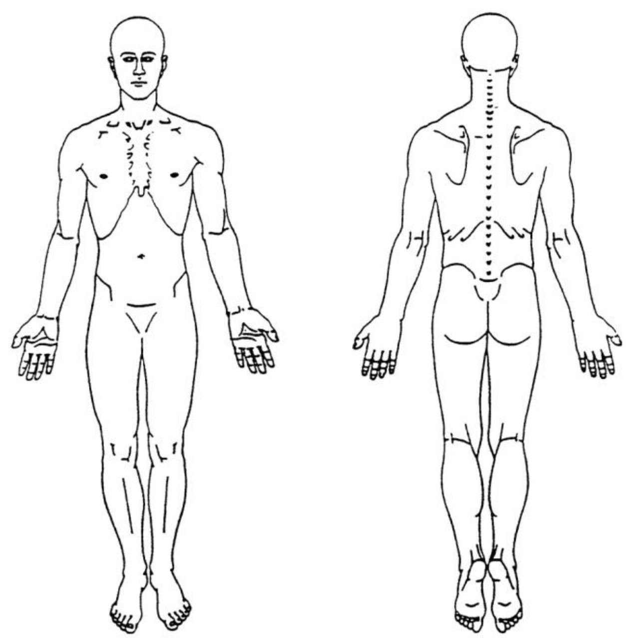

History of Health Concerns

Please start at the top of your body and work your way down.

Symptom 3: ____

- On a scale of 1 – 10, 10 being the worst pain you've ever felt, what is the severity of your symptom?
  1 2 3 4 5 6 7 8 9 10
- What percent of the time do you feel the symptom?
- 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- When did this episode begin? ______________________
- Did it begin: ☐ Suddenly ☐ Gradually
- Describe how it began: __________________________
- Have you had the symptom in the past? ☐ Yes ☐ No
- If yes, when was the first time you've ever felt the symptom: _____________________________________
- What makes the symptom worse?
- ____
- What makes the symptom better?

____

Does the pain radiate? ☐ Yes ☐ No

- If yes, describe in detail where it radiates: ____________
- Does the pain feel worse at a particular time of day?
  ☐ Morning ☐ Afternoon ☐ Early evening ☐ Late at night
  ☐ Unchanged by time of day

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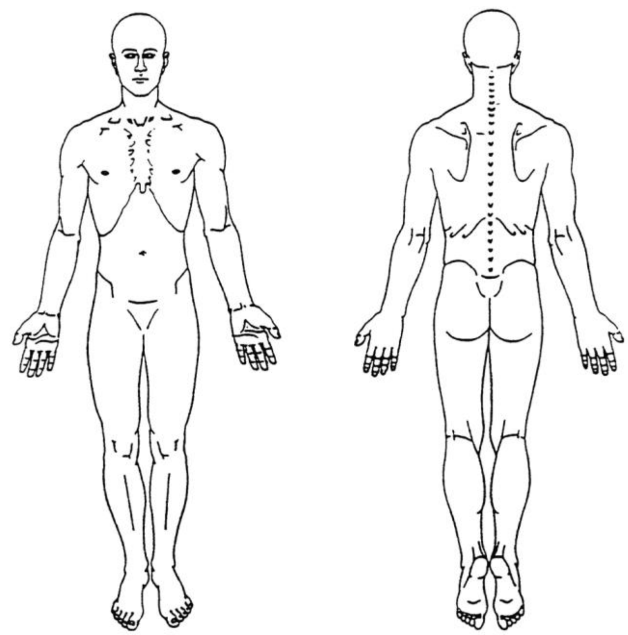

Symptom 4: ____

- On a scale of 1 – 10, 10 being the worst pain you've ever felt, what is the severity of your symptom?
  1 2 3 4 5 6 7 8 9 10
- What percent of the time do you feel the symptom?
- 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- When did this episode begin? ______________________
- Did it begin: ☐ Suddenly ☐ Gradually
- Describe how it began: __________________________
- Have you had the symptom in the past? ☐ Yes ☐ No
- If yes, when was the first time you've ever felt the symptom: _____________________________________
- What makes the symptom worse?
- ____
- What makes the symptom better?

____

Does the pain radiate? ☐ Yes ☐ No

- If yes, describe in detail where it radiates: ____________
- Does the pain feel worse at a particular time of day?
  ☐ Morning ☐ Afternoon ☐ Early evening ☐ Late at night
  ☐ Unchanged by time of day

Please mark on the diagram with the following letters to describe your symptoms:

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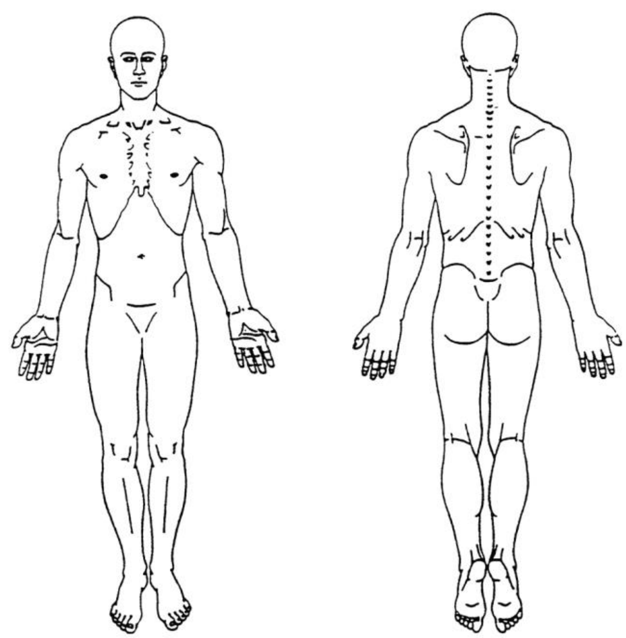

Quadruple Visual Analogue Scale

//Please read carefully//

Instructions: Please circle the number that best describes the question being asked. ***Note**: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.*

Example:

A: headache B: shoulder tightness C: neck pain D: allergies

No Pain ______ D C ______ B ______ A ______ Worst possible pain
0 1 2 3 4 5 6 7 8 9 10

A. ____________ **B.** ____________ **C.** ____________ **D.** ____________

1. What is your pain **RIGHT NOW**?

No pain ________________________________ **Worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

2. What is your **TYPICAL** or **AVERAGE** pain?

No pain ________________________________ **Worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level **AT ITS BEST**? (How close to "0" does your pain get at its best?)

No pain ________________________________ **Worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level **AT ITS WORST?** (How close to "10" does your pain get at its worst?)

No pain ________________________________ **Worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

Other comments: ____

____

Activities of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Activites	No effect	Painful (can do)	Painful (limits)	Unable to perform
Carrying groceries				
Lifting groceries				
Sit to stand				
Climbing stairs				
Pet care				
Driving				
Computer use				
Household chores				
Lifting children				
Concentration				
Bathing				
Dressing				
Shaving				
Sexual activities				
Sleep				
Static sitting				
Static standing				
Yard work				
Walking				
Running				
Sweeping/Vacuuming				
Dishes				
Laundry				
Garbage				
Other:				
Other:				

Social History

1. **Smoking**: ☐ Cigars ☐ Pipe ☐ Cigarettes → **How often?** ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. **Alcoholic beverage**: Consumption occurs → ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. **Recreational drug use**: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. **Hobbies**: Does your present problem affect: ☐ Recreational activities ☐ Exercise regime

   Please explain: ____

Family History

1. Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No

   If yes, whom: ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

   Have they ever been treated for this condition? ☐ Yes ☐ No ☐ I don't know

2. Any other hereditary conditions the doctor should be aware of? ☐ No Yes: ______________________

Condition	Father	Mother	Spouse	Sister	Brother	Children
Arm pain						
Arthritis						
Asthma						
ADD/ADHD						
Allergies						
Back trouble						
Bed wetting						
Cancer						
Carpal tunnel						
Diabetes						
Digestive problems						
Disc problems						
Ear infections						
Fibromyalgia						
Headaches						
Heartburn						
High blood pressure						
Hip pain						
Leg pain						
Menstrual disorder						
Migraines						
Neck pain						
Scoliosis						
Shoulder pain						
Sinus trouble						
TMJ pain						

By signing below, I am acknowledging that I have filled out all the above accurately and to the best of my ability.

*Print Name*________________________________ *Signature*______________________________________ *Date* ________________

Notice of Privacy Practices Acknowledgement

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances.

Permitted Disclosures:

- Treatment purposes – discussion with other health care providers involved in your care
- Inadvertent disclosures – open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room
- For payment purposes – to obtain payment from your insurance company or any other collateral source
- For worker's compensation purposes – to process a claim or aid in investigation
- Emergency – in the event of a medical emergency, we may notify a family member
- For public health and safety – in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public
- To governmental agencies or law enforcement – to identify or locate a suspect, fugitive, material witness, or missing person
- For military, national security, prisoner, and government benefits purposes
- Deceased persons – discussion with coroners and medical examiners in the event of a patient's death
- Telephone calls or emails and appointment reminders – we may call your home/cell and leave voice/text messages regarding an appointment, a missed appointment, or notify you of changes in practice hours or upcoming events
- Announcing names in queue at the front desk & reception area – we announce the first and last names of patients in queue that are waiting to be treated (eg. "Jane Smith, please proceed to room 2"). Please notify the office manager if you would like this to be changed
- Change of ownership – in the event this practice is sold, the new owners would have access to your Personal Health Information

Your rights:

- To receive an accounting of disclosures
- To receive a paper copy of the comprehensive Detail Privacy Notice
- To request mailings to an address different than residence
- To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.

Terms of Acceptance

In order to provide the most effective healing environment, the most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is essential for both parties to be working toward the same objective. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

- Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. It is not the practice of medicine.
- Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustments of vertebral subluxation(s). Subluxations are deviations from normal spinal structures and configurations, and considered to be a partial dislocation. A subluxation that interferes with normal nerve processes is called a neuro-structural shift.
- The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times a day with doctors of chiropractic in the United States alone.
- Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

Informed Consent For Chiropractic Care
Chiropractic Care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is often very minimal. Yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.
Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health, and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, and if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.
By signing below:

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I authorize and request payment of insurance benefits directly to Dr. Joshua Baek and/or Dr. Daniel Baek. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

*Print Name*________________________________ *Signature*______________________________________ *Date* ________________

If this health profile is for a minor/child, please fill out and sign below.

*Name of Practice Member Who is a Minor/Child:*____
I authorize Dr. Joshua Baek and/or Dr. Daniel Baek, and any and all Keystone Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor/child as legally allowed. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority care is revoked or altered, I will immediately notify Keystone Chiropractic.

*Guardian Signature*_____________________________ *Guardian Relationship to Child*___________________ *Date*_______________

We love to have pictures in our office! If you would allow us to have your picture in the office, please sign below.
For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Keystone Chiropractic, or anyone authorized by Keystone Chiropractic, of any and all photographs/videos which were taken of myself and my child, for the purposes of promotional TV, website, social media, and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of Keystone Chiropractic, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentiality, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Keystone Chiropractic to share this information via their website and their social media platforms including but not limited to Facebook and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

*Signature*____ *Date* ________________

X-Ray Authorization
As your health care provider, Keystone Chiropractic is legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays. The fee for the copy is $15 and must be paid in advance. Digital x-rays on a CD will be available within 72 hours of prepayment on any regular practice hours day.

Please Note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctors of Keystone Chiropractic do not diagnose or treat medical conditions. However, the doctors will refer questionable x-ray films to be interpreted by a radiologist hired by Keystone Chiropractic. The radiologist will submit a report of their interpretation to Keystone Chiropractic, and if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below, I am agreeing to the Notice of Privacy Practices Acknowledgement, Terms of Acceptance, X-Ray Authorization, and all the terms and conditions above.

*Print Name*________________________________ *Signature*______________________________________ *Date* ________________

Female Patients Only:
To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time x-rays are taken at Keystone Chiropractic.

*Signature*____ *Date* ______________________________