Date of Birth _____ Social Security Number _____-_____-_____

First Name _____ MI _____ Last Name _____

Address _____

City _____ State _____ ZIP _____

Phone (H) _____ (W)_____ (Cell) _____
(Please circle the preferred contact number)

Email Address _____

Occupation _____ Full Time/Part Time Employer _____

Student Status: Full Time Part Time Marital Status: M S W D Sex: M F

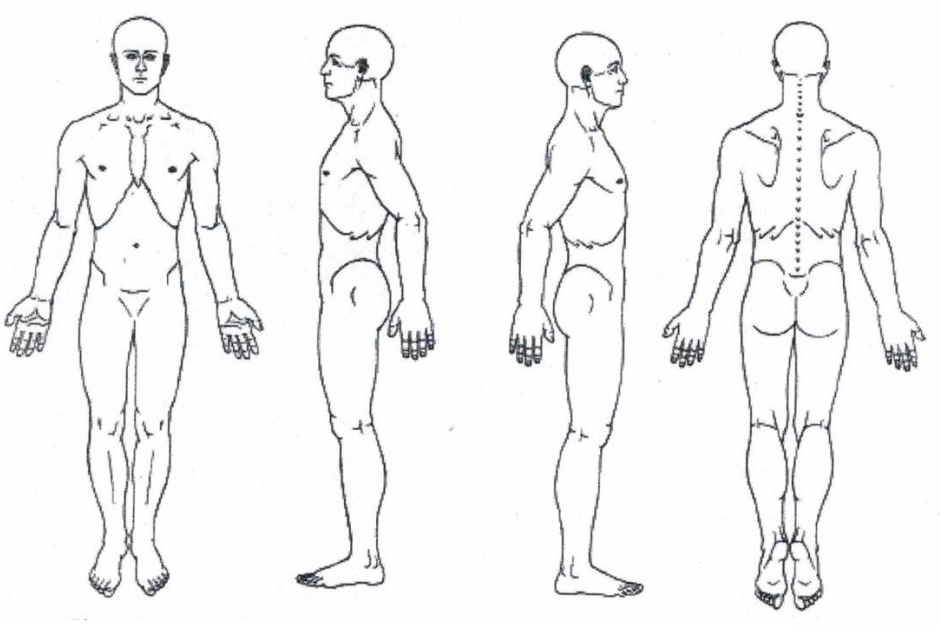
Insurance Company _____ ID Number _____

Have you ever been to another doctor for this problem? Y N If yes who? _____

Emergency Contact Name _____ Contact Number _____

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation
2. Indicate on the drawings below where you have pain/symptoms?



3. How often do you experience your symptoms?
   - □ Constantly (76-100% of the time)
   - □ Occasionally (26-50% of the time)
   - □ Frequently (51 -75% of the time)
   - □ Intermittently (1-25% of the time)
4. How would you describe the type of pain?
   - □ Sharp
   - □ Numb
   - □ Dull
   - □ Tingly
   - □ Diffuse
   - □ Achy
   - □ Burning
   - □ Shooting
   - □ Sharp with motion
   - □ Shooting with motion
   - □ Stabbing with motion
   - □ Electric with Motion
   - □ Stiff
   - □ Other: _____
5. How are your symptoms changing with time? □ Getting Worse □ Staying the Same □ Getting Better
6. On a scale from 0-10 (10 being the worst), rate your problem 0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*
7. How much has the problem interfered with your work?
   - □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely
8. How much has the problem interfered with your social activities?
   - □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely
9. Who else have you seen for your problem?
   - □ Chiropractor
   - □ Neurologist
   - □ Primary Care Physician
   - □ ER Physician
   - □ Orthopedist
   - □ Massage Therapist
   - □ Physical Therapist
   - □ No one
   - □ Other_____
10. How long have you had this problem? _____
11. How do you think the problem began ? _____
12. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No
13. What makes your problem WORSE?

_____

14. What makes your problem BETTER?

_____

15. What concerns you the most about your problem; what does it prevent you from doing ?

16. What is your: Height_____ Weight_____ Date of Birth_____

Occupation_____

17. How would you rate your overall Health? □ Excellent □ Very Good □ Good □ Fair □ Poor

18. What type of exercise do you do ? □ Strenuous □ Moderate □ Light □ None

19. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

20. For each of the following conditions listed below, place a check mark in the "Past" column if you have had the condition in the past. If you have a condition listed below, place a check mark in the "Now" column.

Past	Now		Past	Now		Past	Now	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependence
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Loss of Appetite			
□	□	Ankle/Foot Pain	□	□	Abdominal Pain			**For Females Only**
□	□	Jaw Pain	□	□	Ulcer	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Hepatitis	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Dizziness	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Abnormal Weight Gain/Loss			
□	□	Cancer	□	□	Liver/Gall Bladder Disorder			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	General Fatigue			
□	□	Other:						

21. List all prescription medications you are currently taking:_____

22. List all of the over-the-counter medications you are currently taking:_____

23. List all surgical procedures you have had: _____

24. What activities do you do at work?

□ Sit:	□ Most of the day	□ Half of the day	□ A little of the day
□ Stand:	□ Most of the day	□ Half of the day	□ A little of the day
□ Computer work:	□ Most of the day	□ Half of the day	□ A little of the day
□ On the phone:	□ Most of the day	□ Half of the day	□ A little of the day

25. What activities do you do outside of work?

26. Have you ever been hospitalized □ No □ Yes If Yes, why _____

27. Have you had significant past trauma? □ No □ Yes If Yes, describe_____

28. Anything else pertinent to your visit today? _____

Patient Signature _____ **Date** _____

Kulba Family Chiropractic
& wellness center

5401 Douglas Ave., Suite A
Racine, WI 53402
PHONE: 262-822-8998
FAX: 262-681-8830

HIPPA POLICY

We are very concerned with protecting your privacy and always will respect the privacy of your health information.

The federal laws that protect your protected health information ("HIPAA") allow your health care provider to use or disclose your protected health care information without further authorization or consent from you in a number of circumstances, such as:

- In the course of providing you treatment;
- In the event a referral to another health care provider if/as necessary for the diagnosis, assessment, or treatment of your health condition;
- In the event that another party is potentially responsible for the payment of your services (i.e. Workman's Compensation or Personal Injury Claims);
- For insurance and billing purposes;
- For internal clinic purposes (related to quality control or operations); and
- In limited and unusual circumstances related to public health matters and research.

You have the right to review our Privacy Policy in detail before you sign this consent form. We reserve the right to change our privacy policy. If we make a change, we will notify you in writing when you come in for treatment or by mail.

You have the right to restrict our ability to use or disclose your protected health information with specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, you must inform us in writing.

You have the right to authorize us to disclose your protected health information to specific individuals, companies, or organizations. If you would like to make an authorization, we will ask you to complete an authorization form.

You have the right to revoke any limitation or authorization to use or disclose your protected health information at any time. Your revocation must be in writing. If you refuse to give us an authorization or consent or revoke any authorization or consent in the future, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

Your doctor and members of the practice staff may need to contact you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and to leave messages on your answering machine or with individuals at your home or place of employment.

I acknowledge that I understand the Notice of Privacy Practices as described above on my initial visit. Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices is available upon request in the reception room. We encourage you to read it in full. You may obtain additional copies of our most current notice by requesting it from our staff. If you have any questions regarding this notice of our health information privacy policies, our staff will be happy to assist you.

_____ _____ _____

Patient or Responsible Party **Signature Relationship to Patient** **Date**

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PAYMENT POLICY

Thank you for choosing Kulba Family Chiropractic as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
2. CO-PAYMENT AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help is in upholding the law by paying your co-payment at each visit.
3. PROOF OF INSURANCE. All patients must complete out patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. CONVERAGE CHANGES. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
6. MISSED APPOINTMENT. Our policy is to charge $25.00 after one missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you.
   Please help us to serve you better by keeping your regular scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party **Date**