KULBA FAMILY CHIROPRACTIC

5401 Douglas Avenue Suite A
Racine, WI 53402
262-822-8998
Fax 262-681-8830

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________________________ Contact Number________________

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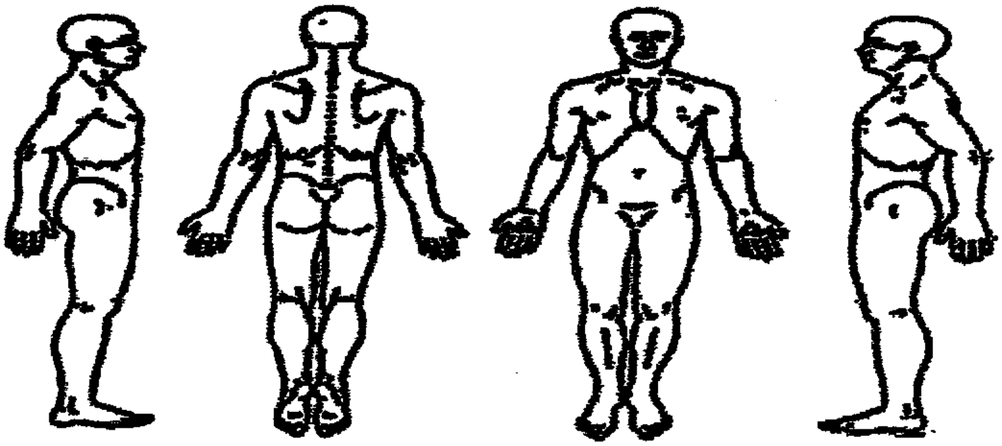
PATIENT INTAKE FORM

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
- ◻ Dull
- ◻ Diffuse
- ◻ Achy
- ◻ Burning
- ◻ Shooting
- ◻ Stiff
- ◻ Numb
- ◻ Tingly
- ◻ Sharp with motion
- ◻ Shooting with motion
- ◻ Stabbing with motion
- ◻ Electric like with motion
- ◻ Other:____________________

5. How are your symptoms changing with time?
◻ Getting Worse ◻ Staying the Same ◻ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you 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
- ◻ ER physician
- ◻ Massage Therapist
- ◻ Neurologist
- ◻ Orthopedist
- ◻ Physical Therapist
- ◻ Primary Care Physician
- ◻ Other:____________
- ◻ No one

10. How long have you had this problem? __________

11. How do you think your 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?
□ Stenuous □ Moderate □ Light □ None

19. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Other__________
□ Heart Problems □ Cancer □ ALS

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ 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 Dependance
□	□ 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	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ 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 the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half 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

28. Anything else pertinent to your visit today?______________________________

Patient Signature______________________________ **Date:**______________

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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