Cascade Chiropractic Clinic, P.C.
Dr. Mark Kline
6151 28th Street, SE
Grand Rapids, MI 49546

Patient Information

Patient Information

NAME:_____ DATE:_____

NICKNAME (HOW WOULD YOU LIKE US TO REFER TO YOU?) _____

DATE OF BIRTH:_____ YOUR SS#:_____

HOME ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE:_____ WORK PHONE:_____

CELL PH:_____ WOULD PREFER: HOME___ WORK___ CELL___

E-MAIL ADDRESS: _____

WHERE ARE YOU EMPLOYED?_____

MARRIED___ SINGLE___ WIDOWED___ DIVORCED___ SEPARATED___

SPOUSE'S NAME_____

SPOUSE'S EMPLOYER_____

HOW WERE YOU REFERRED TO THIS OFFICE?_____

RESPONSIBLE FOR CHARGES AT THIS OFFICE: SELF_____SPOUSE_____
PARENT_____ OTHER _____

IS HEALTH INSURANCE INVOLVED? YES____NO____UNSURE____

HEALTH INSURANCE COMPANY_____

MEMBER ID# _____GROUP# _____INSURED_____

RELATIONSHIP TO INSURED: SELF____SPOUSE____CHILD____OTHER___

INSURED'S SS#_____INSURED'S BIRTH DATE_____

OTHER INSURANCE: YES____NO____

IS YOUR CONDITION RELATED TO AN AUTOMOBILE ACCIDENT? YES____NO___

IS YOUR CONDITION A WORK RELATED INJURY? YES____NO____

FEES ARE PAYABLE AT THE TIME X-RAYS, EXAMINATIONS, AND TREATMENTS ARE RENDERED, UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. X-RAYS REMAIN THE PROPERTY OF CASCADE CHIRORACTIC CLINIC, P.C.. I AUTHORIZE TREATMENT BY DR. MARK KLINE AND AGREE TO THE RELEASE OF INFORMATION NECESSARY FOR MY TREATMENT OR FOR THE PROCESSING OF INSURANCE CLAIMS.

PATIENT'S SIGNATURE: _____ DATE:_____
(PARENT OR GUARDIAN IF A MINOR)

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Health Information

Health Information

1) NAME:_____ 2) DATE:_____

3) MAJOR COMPLAINTS:_____

_____

_____

_____

_____

4) HOW DID THIS CONDITION DEVELOP? _____

_____

5) WHEN DID THIS START?_____

6) HAVE YOU EVER HAD THIS BEFORE? Y __ N __ WHEN? _____

7) THIS HAS BEEN GETTING: BETTER _____% WORSE _____% SAME _____

8) HAVE YOU BEEN SEEN OR TREATED FOR THIS? Y __ N __ HERE? Y __ N __

WHERE? _____

9) WHAT HAVE YOU DONE TO TRY TO RELIEVE THE SYMPTOMS? _____

_____

10) WHAT MAKES THE SYMPTOM(S) WORSE? _____

_____

11) WHAT NORMAL ACTIVITIES HAVE YOU CHANGED SINCE THIS STARTED? _____

_____

12) HAVE YOU HAD ANY ACCIDENTS OR INJURIES (AUTO OR OTHER)? Y __ N __

IF YES DESCRIBE: _____

_____

_____

13) LIST ANY MEDICATIONS YOU ARE TAKING: _____

_____

_____

14) SURGERIES (WHEN): _____

_____

_____

15) HAVE YOU EVER RECEIVED CHIROPRACTIC CARE BEFORE? Y __ N __ WHEN? _____

16) COMMENTS: _____

(Rev. 04-03-12)

DOCTOR _____

DATE OF VISIT ___/___/20___ Patient_____ Age_____

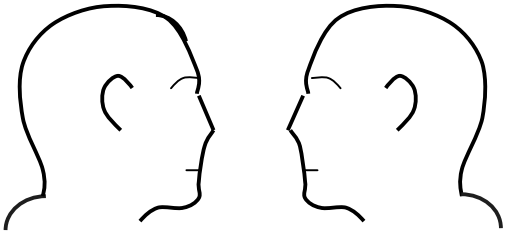
Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms _____

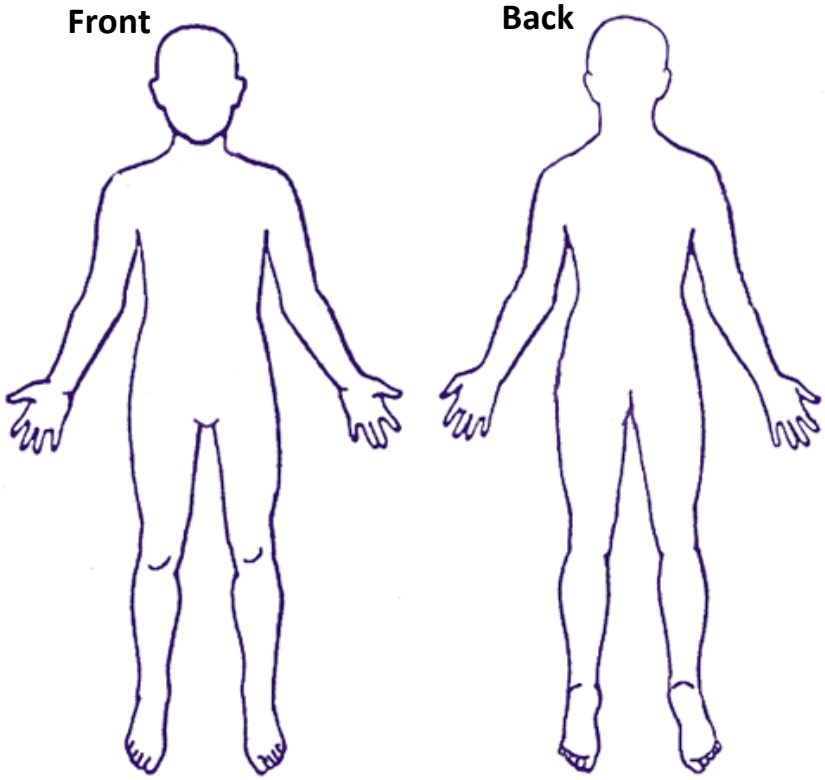
FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? _____

SUBJECTIVE PAIN ASSESSMENT

Right **Left**



Front **Back**



RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A = Ache
B = Burning
ST = Stabbing
SP = Spasm
N = Numbness
P = Pins and Needles
T = Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**

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Pre X-Ray

Pre X-Ray

1) NAME: _____ 2) PATIENT'S DOB:_____

IT IS THE POLICY OF THIS OFFICE TO TAKE THE UTMOST OF PRECAUTIONARY MEASURES TO PREVENT UNNECESSARY X-RAY EXPOSURE TO ANY PATIENT, BUT ESPECIALLY THE UNBORN. PLEASE LET US KNOW IMMEDIATELY IF YOU ARE PREGNANT. WE WILL BE HAPPY TO SUPPLY YOU WITH INFORMATION REGARDING THE RISKS OF X-RAY EXPOSURE UNDER THESE OR ANY CIRCUMSTANCES. THE QUESTIONS BELOW ARE FOR THE PURPOSES OF IDENTIFYING OCCASIONS WHEN DELAYING X-RAY PROCEDURES AND CONSULTATION WITH YOUR MEDICAL DOCTOR ARE REQUIRED.

3) HAVE YOU EVER HAD ANY DEVICE SURGICALLY IMPLANTED? Y ___ N ___

IF SO, WHAT AND WHEN? _____

_____

SURGICAL PHYSICIAN: _____

4) IS THERE ANY CHANCE OF YOU BEING PREGNANT? Y ___ N ___

BEGINNING DATE OF LAST MENSTRUAL CYCLE: _____

NAME OF OB/GYN: _____

5) PATIENT'S SIGNATURE: _____
(PARENT OR GUARDIAN IF A MINOR)

6) DATE: _____ 7) STAFF INITIALS: _____

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Understanding Records

Understanding Records

Each time you visit a hospital, physician or other health care provider, a record of your information is made. Typically this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. We use this information, often referred to as your health or medical record, to serve as a basis for planning your care and treatment, as a means to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. In any other situation, we will ask you for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where and why others may access your health information and make more informed decisions when authorizing disclosures to others.

We may at times leave a message on your answering machine or voice mail regarding your appointments or if we have questions regarding your insurance.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You may also request a copy of our notice at any time. For more information about our privacy practices, contact Dr. Mark Kline at the address listed above.

Individual Rights

In most cases you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge 5 cents for each page. You also have the right to receive a list of instances when we have disclosed health information about you for reasons other than treatment, payment or other related administrative purposes. If you believe that information in your record is incorrect, or is important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally required to accept it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Dr. Mark Kline at the address listed above. You may also send a written complaint to the U.S. Department of Health and Human Services. Dr. Mark Kline can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

Acknowledgement

I acknowledge receipt of this notice of information practices. I understand that I may request additional restrictions on the use and disclosure of my protected health information or for additional confidential treatment of communications.

PATIENT'S SIGNATURE: _____
(PARENT OR GUARDIAN IF A MINOR)

PRINT NAME: _____ **DATE:** _____

(REV. 05-07-2009)