

PATIENT INTAKE FORM

Dr. Corinne A Kennedy of Kennedy Chiropractic Center
11515 W. North Avenue -Ste. A- Wauwatosa WI 53226
414-443-1515

Office Use Only Patient #: _____

Patient Name: _____	Date: ____/____/____					
First Middle Last						
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth day: ____/____/____	Age: ____	Social Security Number: _____			
Address: _____						
City: _____	State: _____	Zip: _____				
Cell Number: (____) _____	Home Number: (____) _____					
E-Mail: _____@_____						
EMERGENCY CONTACT: _____ PHONE #: (____) _____ RELATION: _____						
<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Widow	<input type="checkbox"/> Minor	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Partnered _____ Years
<input type="checkbox"/> Employed	<input type="checkbox"/> Full-Time Student	<input type="checkbox"/> Part-Time Student	<input type="checkbox"/> Retired	<input type="checkbox"/> Other _____		
Whom Can We Thank For Your Referral? _____						

EMPLOYMENT/SCHOOL INFORMATION	
Patient Employer/School: _____	Occupation: _____
Employer/School Address: _____	Phone: (____) _____

INSURANCE INFORMATION	
Primary Insurance Company: _____	
ID #: _____	Group #: _____
Secondary Insurance Company: _____	
ID #: _____	Group #: _____
If your insurance is provided through your spouse, parent, guardian, etc., please complete below:	
Insurance: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	
Responsible Party's Name: _____	
Responsible Party's Date of Birth: ____/____/____	
Relationship to Responsible Party: _____	
Responsible Party's Employer _____	

Kennedy Chiropractic Center Will Provide A Complimentary Insurance Check At Your Request

PATIENT INSURANCE RESPONSIBILITIES

Dr. Corinne A. Kennedy of Kennedy Chiropractic Center
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The purpose of Chiropractic services is to promote health naturally, through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict a time schedule or effectiveness of Chiropractic procedures. Sometimes the response is immediate, but in most cases, gradual. Occasionally, the results are longer than expected. There may be more than one condition to work on, therefore, care may vary in length of time.

As a patient of KCC, you are giving the doctor permission and authority to care for yourself or a minor in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course will not give a Chiropractic adjustment, or health care, if she feels the treatment may be contraindicated. It is the responsibility of the patient to make sure it is known or to learn through health care procedures whatever he/she is suffering from, be it latent pathological defects, illness, or deformities which would otherwise not come to the attention of Dr. Kennedy.

In some cases, KCC fees are not covered, in full, by your insurance company. We want our patients to be aware of the fact that under any circumstances, the patient is personally responsible for any balance due after insurance has paid. KCC expects full payment within 30 days upon receipt of your statement. Any unpaid balance after 30 days will be charged a 1.5% monthly interest fee until all unpaid balances are paid in full. This balance due including provisions set by your insurance company, such as co-payments, co-insurances, deductibles and "usual and customary" allowances. The policy held by you or your employer is a contract between the policy holder and the insurance company. KCC does not accept insurance companies as patients; you are the patient. As the patient, you understand that you are financially responsible for all charges, whether paid by the insurance company or not. If you are unfamiliar with your insurance coverage, we ask that you discuss this with your employer or your insurance company before any charges are incurred. If your insurance requires any specific forms please bring those to our attention so that we can submit them prior to your care. It is always best for you to understand your coverage before beginning treatment, so you know what you are responsible for. We will do a complimentary benefits check for you, however, this is only an estimate of coverage and not a guarantee of payment. Your policy always rules as it applies on the day of service.

I consent to allow Kennedy Chiropractic Center to use and or disclose my Protected Health Information in compliance with their policy as indicated in their Notice of Patient Privacy Practices. My signature allows KCC to use my personal information for insurance purposes, including an assignment of benefits.

X _____ Date: ____/____/____

OTHER PATIENT RESPONSIBILITIES

In order to provide you and other patients with optimal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Kennedy Chiropractic Center asks that you give us a 24 hour notice if you need to cancel or change your scheduled appointment time. If we do not receive sufficient notice or you do not show for your appointment, you will be charged a \$10 fee before rescheduling your next appointment. In the hope of maintaining good, open communication and understanding between you and Dr. Kennedy. If you have any questions, please ask Dr. Kennedy or the front desk staff member.

X _____ Date: ____/____/____

I acknowledge that I have seen, and been offered a copy of the Kennedy Chiropractic Center **Notice of Privacy Practices**, and been given an opportunity to review and understand it. The notice brochure describes the types of uses and disclosures of my **Protected Health Information** that might occur in my treatment, payment of my bills or in the performance of health care operations. The notice brochure also describes my rights and duties of KCC with respect to my **Protected Health Information**.

X _____ Date: ____/____/____

I give permission for my **Personal Health Information** to be released to the following people upon their request.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

X _____ Date: ____/____/____

CONFIDENTIAL HEALTH QUESTIONNAIRE— PRESENT HISTORY

Dr. Corinne A. Kennedy of Kennedy Chiropractic Center
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1. Reason For Visit: _____
2. Describe Current Symptoms: _____
3. Date Symptoms Began: _____ Related To: Work Injury Auto Accident Other _____
4. Describe How Your Symptoms Began: _____

5. How Often Do You Experience Your Symptoms:

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Intermittently (26-50% of the day)
- Occasionally (0-25% of the day)

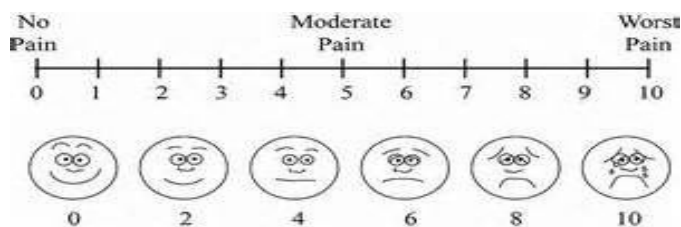
6. Type Of Pain Felt:

- Sharp Shooting
- Dull Ache Burning
- Numbness Tingling
- Throbbing Stiffness

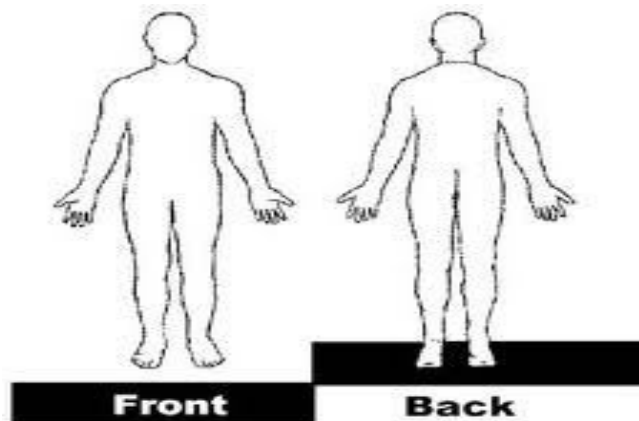
7. Does Your Pain Interfere With:

- Work Bending
- Daily Routine Sleep
- Driving Sitting
- Standing Walking

8. Please Rate Your Pain On A Scale From 1-10



Please Indicate Where You Have Pain Or Other Symptoms



9. How Are Your Symptoms Changing?

- Getting Better
- Not Changing
- Getting Worse

10. What Is Your Occupation? _____ Stress Level (1-10) _____

11. Do You Smoke? _____ Do You Drink Alcohol? _____

12. Have You Had Similar Symptoms In The Past? (If Yes, Explain) _____

13. Have You Seen Any Health Care Professionals For Your Current Symptoms? (If Yes, What Was The Treatment Plan) _____

14. Have You Had Any Tests Performed For Your Current Symptoms? _____

15. Are You Currently Taking Any Medication/Vitamins? (If Yes, Please List) _____

16. Do You Have Any Allergies? (If Yes, Please List) _____

17. Are You Currently Pregnant? _____ Date Due: _____

CONFIDENTIAL HEALTH QUESTIONNAIRE—PAST HISTORY

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1. Date Of Last Physical Exam? ____/____/____ Spinal X-ray? ____/____/____ Blood Test? ____/____/____
2. Have You Had Any Surgeries? _____ When? ____/____/____
3. Have You Had Any Serious Illnesses Or Conditions ? _____ When? ____/____/____
4. Have You Been Treated By A Physician For Any Health Condition In The Past Year? _____ When? ____/____/____
5. Have You Had Any Serious Falls? _____ When? ____/____/____
6. Have You Had Any Head Injuries? _____ When? ____/____/____
7. Have You Had Any Broken Bones? _____ When? ____/____/____

Please Circle All Symptoms You Have Had In The Last 6 Months

Alcoholism	Emphysema	Multiple Sclerosis	Thyroid Disease
Allergy Shots	Epilepsy	Nervousness/Anxiety	Tuberculosis
Anemia	Fractures	Numbness	Ulcers
Anorexia	Glaucoma	Osteoporosis	
Appendicitis	Gout	Pacemaker/Defibrillator	
Arthritis	Headaches	Parkinson's Disease	
Asthma	Heart Disease	Pinched Nerve	
Backaches	Hepatitis	Pneumonia	
Bleeding Disorder	Herniated Disc	Polio	
Cancer	High Cholesterol	Prostate Issue	
Cataracts	Kidney Disease	Prosthesis	
Chemical Dependency	Liver Disease	Psychiatric Care	
Chicken Pox	Measles	Rheumatoid Arthritis	
Depression	Migraine	Scarlet Fever	
Diabetes	Miscarriage	Sinus Issue	
Dizziness	Mononucleosis	Stroke	