

Dr. Brent A. Kaiser, D.C.

Chiropractic Physician

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name Middle Last Name

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth (Month/Day/Year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Please initial and date the bottom right hand corner of each page)**



**Insurance Information:**

(Please provide your insurance card at your first visit)

Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your policy currently active? \_\_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_\_ No

Policy Owner Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Policy Owner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse/Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Please initial and date the bottom right hand corner of each page)**



Primary Complaint (#1 Reason for your appointment):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Onset Date (When did you first notice the problem?): \_\_\_\_\_\_\_\_\_\_\_\_

What is the cause of your primary complaint? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency (circle): Constant Frequent Occasional Intermittent

Intensity (“1” Minimal – “10” Severe): 1 2 3 4 5 6 7 8 9 10

Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Dull - Sharp - Shooting - Stiff - Weak - Burn - Numb/Tingling)

Aggravated by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relieved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past History of Condition? \_\_\_\_\_\_ Treatments? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tests performed for this condition? X-ray MRI CT Scan NCV/EMG

**(Please initial and date the bottom right hand corner of each page)**



Additional Complaint (#2):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Onset Date (When did you first notice the problem?): \_\_\_\_\_\_\_\_\_\_\_\_

What is the cause of your primary complaint? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency (circle): Constant Frequent Occasional Intermittent

Intensity (“1” Minimal – “10” Severe): 1 2 3 4 5 6 7 8 9 10

Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Dull - Sharp - Shooting - Stiff - Weak - Burn - Numb/Tingling)

Aggravated by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relieved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past History of Condition? \_\_\_\_\_\_ Treatments? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

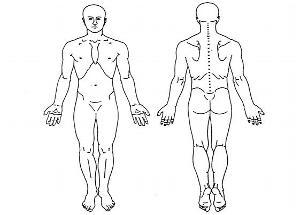
Tests performed for this condition? X-ray MRI CT Scan NCV/EMG

**(Please initial and date the bottom right hand corner of each page)**



Use the following scale to mark and describe your symptoms.  Pain(P), Tingling (T),

Numbness (N), Stiffness (S), Burning (B).  Write in any additional symptoms if necessary.



**(Please initial and date the bottom right hand corner of each page)**



If you have experienced any of the following conditions in the past mark a “P” on the line provided. If you are currently experiencing any of the following conditions please mark a “C” on the line provided. (check all that apply)

\_\_\_ heart attack              \_\_\_ stroke                \_\_\_ difficulty with bowel movements

\_\_\_ diabetes (1) \_\_\_ diabetes (2) \_\_\_ difficulty with urination

\_\_\_ glaucoma \_\_\_ fainting \_\_\_ kidney stones

\_\_\_ bloody stools \_\_\_ arthritis \_\_\_ prostate trouble

\_\_\_ dizziness \_\_\_ anemia \_\_\_ diverticulosis

\_\_\_ asthma \_\_\_ dizziness \_\_\_ sudden weight loss

\_\_\_ headache \_\_\_ ears ringing \_\_\_ shortness of breath

\_\_\_ diarrhea \_\_\_ ulcers \_\_\_ knee/hip replacement

\_\_\_ broken bones \_\_\_ gout \_\_\_ shoulder replacement

\_\_\_ migraine \_\_\_ nausea \_\_\_ muscle cramps

\_\_\_ STD’s \_\_\_ epilepsy \_\_\_ sleeping disturbances

\_\_\_ turberculosis \_\_\_ soreness \_\_\_ constipation/bowels

\_\_\_ chest pain \_\_\_ memory loss \_\_\_ menstrual cramping

\_\_\_ fatigued/tired \_\_\_ autoimmune \_\_\_ high blood pressure

\_\_\_ other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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General Activities (check all that apply)

\_\_\_ Sports/Exercise (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Computer Use (Hours/ day? Work/Pleasure?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Poor Sleeping Habits (Couch? Recliner? Futon?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature (signature of parent if the patient is a minor)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Financial Arrangements

* **Cash Patient:** Payment is due prior to treatments. We accept AMEX, Visa, Mastercard, Check and Cash payments.
* **Insurance Patient:** Professional services are rendered and billed to your Insurance Company on your behalf. Any services not covered by your insurance company are ultimately your responsibility and should be paid to our office.
* **Collections/Attorney Fees:** I agree to pay all costs of a collection agency if necessary to obtain payment in the event legal action is necessary to collect an unpaid balance for my professional services. I agree to pay reasonable attorney’s fees or other such costs the court determines proper.
* **Limited Release of Medical Information:** I authorize Hoosier Pain and Posture LLC to make inquiries and to release any pertinent information to any insurance company, adjuster or attorney to facilitate collection under these assignments.
* **Assignment of Cause of Action:** In the event any third party obligated to make payment to me **or** Hoosier Pain and Posture LLC for services refuses to make payment, I hereby assign, transfer and convey to Hoosier Pain and Posture LLC any and all cause of action that might exist in my favor against any such company or person. I authorize Hoosier Pain and Posture LLC to prosecute said action in my name “or” their name to collect these fees and legal expenses and to resolve these claims as they see fit.

**Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**