Integrated Body and Medicine
Kennedy Avenue Chiropractic

8145 Kennedy Ave.
Highland, IN 46322
219-803-6651

Patient name: ________________________________ Patient DOB:____/____/______ Date: ____/____/______ MRN _______

SS #/SIN___________________ Sex: ☐ Male ☐ Female Age: ______ Home phone____________ Cell Phone _______________

Check appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated Email: ______________________

Patient's Address ____City _______________ State______ Zip________________

Employer Name: ____

Spouse or Patient's Guardian name_____________________________ Spouse's Employer_____________________________________

Whom may we thank for referring you? ____

Person to contact in case of an emergency____ Phone_______________________________

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

____ _______________________________________

Parent or Guardian Date

Responsible Party

Name of The Person responsible for this account ______________________________Relationship to Patient ______________________

Address ____Home Phone ______________________________

E-Mail ____Cell Phone _______________________________

Driver's License # _________________________________ Date of Birth: ____

Is the person currently a patient at our office? ☐ Yes ☐ No

Do you have any Medical insurance? ☐ Yes ☐ No if yes, complete the following:

Name of the insured____ Relationship to patient__________________________

Birthdate___________________ SS#/SIN_________________________ Name of Employer_________________ Work Phone __________

Address of Employer____ State ____________ Zip________________________________

Insurance Company______________________________ Group #__________________ Union or local # ___________________________

Ins. Co. Address _____________________________________ City _________________ State _________ Zip________________________

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Integrated Body and Medicine/Kennedy Avenue Chiropractic** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this ______ day of _________________, 20 ____. X____________________________ (SEAL)
(patient signature)

X______________________________(SEAL) X______________________________
(signature of Guardian if applicable) (please print patient name)

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Patient name: _________________________________ Patient DOB:____/____/______ Date: ____/____/______ MRN _______

Health History

Chief Complaint: ____

History of Present illness:

Location: ____________________________________
(Where is the pain/problem?)

Quality: ____________________________________
(Example: normal vs abnormal color, activity, etc..)

Severity: ____________________________________
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: ____________________________________
(How long have you had this pain/ problem? When did it Start?)

Timing: ____________________________________
(Does the pain/problem occur at a specific time?)

Context: ____________________________________
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms ____________________________________
____
(What other associated problems have you been having?)

Modifying Factors ____________________________________
____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (check "yes" or "no"/ leave blank if you are uncertain.)

Measles	☐ NO	☐ YES	Anemia	☐ NO	☐ YES	Back Trouble	☐ NO	☐ YES	Hepatitis	☐ NO	☐ YES
Mumps	☐ NO	☐ YES	Bladder Infection	☐ NO	☐ YES	High Blood Pressure	☐ NO	☐ YES	Ulcer	☐ NO	☐ YES
Chicken Pox	☐ NO	☐ YES	Epilepsy	☐ NO	☐ YES	Low Blood Pressure	☐ NO	☐ YES	Kidney Disease	☐ NO	☐ YES
Whooping Cough	☐ NO	☐ YES	Migraine Headaches.	☐ NO	☐ YES	Hemorrhoids	☐ NO	☐ YES	Thyroid Disease	☐ NO	☐ YES
Scarlet Fever	☐ NO	☐ YES	Tuberculosis	☐ NO	☐ YES	Date of Last Chest X-Ray__________			Bleeding Tendency	☐ NO	☐ YES
Diphtheria	☐ NO	☐ YES	Diabetes	☐ NO	☐ YES	Asthma	☐ NO	☐ YES	Any Other Disease	☐ NO	☐ YES
Small pox	☐ NO	☐ YES	Cancer	☐ NO	☐ YES	Hives of Eczema	☐ NO	☐ YES	Mitral Valve Prolapse	☐ NO	☐ YES
Pneumonia	☐ NO	☐ YES	Polio	☐ NO	☐ YES	AIDS & HIV…	☐ NO	☐ YES	Other Please List: ______________		
Rheumatic Fever	☐ NO	☐ YES	Glaucoma	☐ NO	☐ YES	Infectious Mono	☐ NO	☐ YES	______________________		
Arthritis	☐ NO	☐ YES	Hernia	☐ NO	☐ YES	Bronchitis	☐ NO	☐ YES	______________________		
Venereal Disease	☐ NO	☐ YES	Blood or Plasma Transfusion	☐ NO	☐ YES	Stroke	☐ NO	☐ YES	______________________		

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

______________________ ______________ ______________________
______________________ ______________ ______________________
______________________ ______________ ______________________

Medications: (include nonprescription)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion?
O yes O no if yes what type: ______________________________

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Patient Social History:

Marital Status	Single: ______	Married: ______	Separated: _______	Divorced: _______	Widowed: _______
Use of Alcohol	Never: ______	Rarely: _______	Moderate: _______	Daily: ________	
Use of Tobacco	Never: ______	Rarely: _______	Moderate: _______	Daily: _________	
Use of Drugs	Never: ______	Type/Frequency: ____			
Excessive Exposure					
At home or at work to:	Fumes: ______	Dust: ______	Solvents: ______	Airborne Particles: _______	Noise: _______

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	________	____________________________________	______________________________
Mother	________	____________________________________	______________________________
Siblings	________	____________________________________	______________________________
	________	____________________________________	______________________________
	________	____________________________________	______________________________
Spouse	________	____________________________________	______________________________
Children	________	____________________________________	______________________________
	________	____________________________________	______________________________
	________	____________________________________	______________________________

<u>Indicate which of the below you have experienced in the last 1-2 months</u>

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

<u>Eyes/Ears/Nose/Throat/Respiratory</u>

Asthma	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Stuffy Nose	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Hay Fever	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Sore throat	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Chronic Cough	☐ 1 ☐ 2 ☐ 3 ☐4 ☐ 5
Chest Congestion	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Frequent Sneezing	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Itchy/Watery Eyes	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Drainage	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Earache or Ear Infection	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

<u>Muscular/Skeletal</u>

Muscle Aches	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Fibromyalgia	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Arthritis	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Joint Pain	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Low Back Pain	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Neck Pain	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Wrist/Hand Pain	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Elbow Pain	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Shoulder Pain	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Hip Pain	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

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Itching	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Hoarseness	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Shortness of Breath	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Wheezing	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Knee Pain	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Ankle/Foot Pain	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Pain b/t shoulder blades	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Neurological

Headaches	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Migraines	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Dizziness	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Numbness	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Tingling	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Pins/needles in hands or feet	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

General

Fatigue	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Malaise	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Weakness, tiredness	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Lightheadedness	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Irritability	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Constipation	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Diarrhea	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Feeling foggy	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Forgetfulness	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

____ ______/______/__________

Signature of the Patient, Parent or Guardian **Date**

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Provider Signature: ____ Date: ____/____/______