APPLICATION FOR CARE AT Knoxville Chiropractic Solutions

A Division of The Beckett Corp.

Today's Date: __________________ HRN: ____________________

PATIENT DEMOGRAPHICS

Name: ____ Birth Date: _____-_____-_____ Age: _______ ☐ Male ☐ Female
Address: ____ City: __________________________________ State: _____ Zip: ______________
E-mail Address: _____________________________________ Home Phone: ____________________________ Fax: _______________________
Mobile Phone: ______________________________________ Work Phone: ____________________________ Fax: _______________________
Social Security #: ___________________________________ Driver's License #: ____
Employer: ____ Occupation: ____
Name of Spouse: ____________________________________ Spouse's Employer: ____
Occupation: ____ Names and Ages of your children: ______________________________________
Name & Number of Emergency Contact: ____Relationship: _____________________________

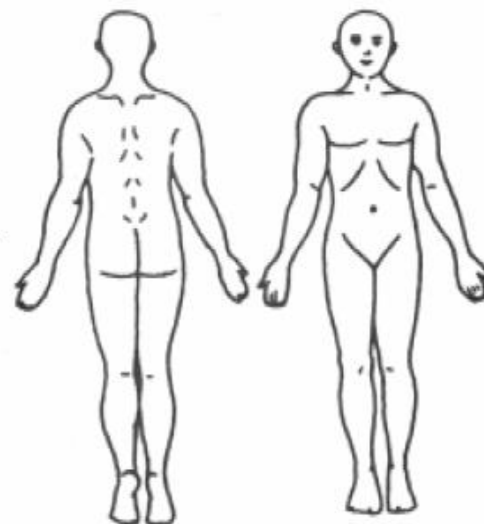
HISTORY of COMPLAINT(s)

Please list in order of importance all complaints and the symptoms you are currently experiencing that brought you to this office:
Primary problem ____ 2nd _____________ 3rd _____________ 4th_____________
When did each **problem/symptom begin**: Primary complaint _____________ 2nd _____________ 3rd _____________ 4th_____________
Number of times you have experienced: Primary complaint _____________ 2nd _____________ 3rd _____________ 4th_____________
When was the last **episode**? Primary complaint _____________ 2nd _____________ 3rd _____________ 4th_____________
What relieves your symptom(s)? Primary complaint _____________ 2nd _____________ 3rd _____________ 4th_____________
What makes them feel worse? Primary complaint _____________ 2nd _____________ 3rd_____________ 4th_____________
Please mark with a "**C**" if you feel your pain constantly or an "***I***" if you experience it intermittently on the line next to each compliant:
Primary problem ___ 2nd ___ 3rd ___ 4th ___

On a scale of **1 to 10** with**10** being the worst pain and **0** being no pain, rate how you feel today ***(Circle the number)***:

Primary or chief complaint	0	1	2	3	4	5	6	7	8	9	10
Second complaints	0	1	2	3	4	5	6	7	8	9	10
Third complaint:	0	1	2	3	4	5	6	7	8	9	10
Fourth complaint::	0	1	2	3	4	5	6	7	8	9	10
Fifth	0	1	2	3	4	5	6	7	8	9	10

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms: **R = R**adiating **B = B**urning **D = D**ull
A = Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling



Do your symptoms cause you to feel worse in the ☐ AM ☐ PM ☐ mid-day ☐ late PM
Have these Problems ever been treated by anyone in the past? ☐No ☐Yes **If yes**
Who provided: ____
How long ago? ______What **type** of treatment did you receive? ______________________
What were the **results?** ☐ Favorable ☐ Unfavorable → **If unfavorable** please explain:
____
List any **medications** taken to treat these conditions:___________________________________
Did they help? ☐ No ☐ Yes If you still take them, how often? _______________________
Have you ever been under chiropractic care? ☐ No ☐ Yes **If yes,** how long ago: ________
Name of Previous Chiropractor: ____
Are any of your problem(s) today the result of ANY **recent accident**? ☐ No ☐ Yes **If yes,**
How long ago? ________ Please explain what type of accident: ____________________

PAST HISTORY

1. If you have ever been diagnosed with any of the following conditions please indicate with a **P** for in the **Past, C** for **Currently** have and **N** for **Never** have had:
___ Heart Attack ___ Dislocations ___ Tumors ___ Stroke ___ Seizure
___ Broken Bone ___ Concussion ___ Disability ___ Cancer ___ Rheumatoid Arthritis
___ Osteo Arthritis ___ Fracture ___ Diabetes ___ Other serious conditions {*Doctors add other possible contraindications here*}

2. PLEASE**, identify** ALL PAST **and or any** unrelated current **conditions you feel may be contributing your present problem:**

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
PREVIOUS ACCIDENTS			
ADULT DISEASES			

SURGERIES ____

Please check all symptoms that you have ever had, even if they do not seem to be related to your current problem.

__ Headaches	__ Loss of smell	__ Ringing in ears	__ Stomach upset
__ Pins and Needles in arms	__ Buzzing in ears	__ Loss of taste	__ Tension
__ Dizziness	__ Numbness in toes	__ Irritability	__ Cold feet
__ Numbness in fingers	__ Depression	__ Cold Hands	__Hot flashes
__ Fatigue	__ Neck stiff	__ Fever	__ Heartburn
__ Sleeping problems	__ Constipation	__ Problems urinating	__ Ulcers
__ Diarrhea	__ Lights bother eyes	__ Menstrual Irregularity	__Cold Sweats
__ Mood swings	__ Fainting	__ Loss of balance	__ Menstrual Pain
__ Pins and needles in legs	__ Back Pain	__ Nervousness	__ Neck Pain

5. Please mark with an X under columns 2, 3, 4 and 5, the effect your current condition is having on your ability to perform the 'ACTIVITIES'

ACTIVITIES OF DAILY LIFE	I CANNOT DO AT ALL PAIN IS TOO GREAT	CAN DO BUT ALWAYS EXPERIENCE MODERATE TO SEVERE PAIN	CAN DO BUT EXPERIENCE MODERATE PAIN	CAN DO BUT EXPEREINCE MILD PAIN
REACHING				
STANDING for > ____ hours				
SITTING for > _____ hours				
SITTING TO STANDING				
LYING TO SITTING				
RUNNING				
WALKING				
PUSHING				
PULLING				
BENDING WHILE SITTING				
BENDING WHILE STANDING				
CLIMBING STAIRS				
LIFTING _________________ (what or what weight)				
BENDING HEAD forward				
TURNING HEAD to ___ side				
EXERCISING				
SPORTS				
HOBBIES				
SWIMMING				
LIE ON BACK				
SEXUAL ACTIVITIES				

I have provided the practice with a true and accurate past history of all health conditions, as well as the type of care I received for those conditions and described to the best of my ability my present problems and all the previous attempts to remedy my problems which may or may not have been successful.

____ _____ - _____ - _____

Patient or Authorized Person's Signature Date Completed

Reviewed by ____ _________________

Knoxville Chiropractic Solutions Dr. Shana Sparks
7217 Clinton Highway, Suite D&E, Powell, TN 37849 Phone: 865-333-0999

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be offered a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

______________________________	______________________________
Printed Name	Authorized Provider Representative
______________________________	______________________________
Signature	Date

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APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to 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 information and to leave messages on your answering machine or with individuals at your home or place of employment.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of ____________________(today's date). This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

______________________________	______________________________
Patient Name Printed	Date
______________________________	______________________________
Patient Signature	Authorized Provider Representative

Informed Consent to Chiropractic Care

I hereby request to consent to the performance of chiropractic with adjustments, including various modes of physical therapy on me by the licensed Doctors of Chiropractic, who may be employed by or engaged in practice. I have had an opportunity to discuss with the doctor named below, the nature and purpose of chiropractic treatment and other procedures. I understand that as with all medical treatment, no results are guaranteed. I further understand that there are some very slight risks to chiropractic treatment. These include, but are not limited to, muscle strains, sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate, all risks or complications. I have also been informed that if my condition worsens, I shall contact Dr. Shana Sparks during office hours for an emergency appointment. I agree to receive all treatments deemed necessary by the treating doctor. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

______________________________	______________________________
Printed Name	Signature
______________________________	______________________________
Date	Doctor's Signature

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PATIENT CONSENT FOR DIAGNOSTIC X-RAY

I authorize Dr. Shana Sparks to perform any diagnostic x-ray(s) that she may consider necessary or advisable during the course of my examination and/or treatment.

Print Name: ___________________________ **Signature**: ______________________________

Date: ____/____/____

FEMALE PATIENTS: (Regarding the possibility of pregnancy)

This certifies, to the best of my knowledge, that I, ______________________________ am not pregnant. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child. I give Dr. Shana Sparks permission to perform diagnostic x-ray(s) that she may consider necessary or advisable.

Print Name: ___________________________ **Signature**: _______________________________

Date: ____/____/____

Minor Patients:

I am the parent or legal guardian of ___________________________________ who is a minor, ______ years of age. I authorize Dr. Shana Sparks to perform diagnostic x-ray(s) as she may consider necessary or advisable for this minor.

Print Name: ___________________________ **Signature**: _______________________________

Date: ____/____/____