Patient History

Date: _____ Doctor: Charles Kelly Donna Kelly Patient #: _____
Name: _____ Referred by: _____
Address: _____ City: _____State: ____ Zip: _____
E-mail: _____ Phone #: _____ Cell# _____
Birth date: _____Age: _____ Marital status: S M D W
Spouses name: _____ # of children: _____ Emergency contact: _____
Occupation: _____ Employer: _____ Work #: _____
Social Security #: _____ Last Chiropractic visit? _____ Dr. _____

Major complaints: _____
_____
How long have you had this condition? _____ Date condition began: _____
How did this condition begin? _____
Have you lost work days? Yes No If yes, how many? _____
Have you had this similar condition in the past? Yes No When? _____
Is this condition related to a work accident? Yes No Date of accident: _____
Is this condition related to an auto accident? Yes No Date of accident: _____
Do you have health insurance? Yes No Name of insurance company: _____
Do you have secondary health insurance Yes No Name of insurance company: _____

C=Current Condition P=Past Condition N/A=Not Applicable

Fractured bones	C	P	N/A	Loss of memory	C	P	N/A	Lung problems	C	P	N/A
Auto accidents	C	P	N/A	Learning disability	C	P	N/A	Difficulty breathing	C	P	N/A
Other accidents/falls	C	P	N/A	Mistake sidedness (R from L)	C	P	N/A	Wheezing	C	P	N/A
Knocked unconscious	C	P	N/A	Stutter	C	P	N/A	Heart problems	C	P	N/A
Back curvature	C	P	N/A	Lose temper easily	C	P	N/A	Stroke	C	P	N/A
Mental or emotional disorder	C	P	N/A		C	P	N/A	High or low blood pressure	C	P	N/A
Arthritis	C	P	N/A	Headache	C	P	N/A	Varicose veins	C	P	N/A
Diabetes	C	P	N/A	Neck pain or stiff (Rt Lt)	C	P	N/A	Liver trouble	C	P	N/A
Swollen or painful joints	C	P	N/A	Numbness, tingling of pain in	C	P	N/A	Gall bladder trouble	C	P	N/A
Convulsions/epilepsy	C	P	N/A	arms, hands, fingers (Rt Lt)							
Skin problems	C	P	N/A	Jaw pain or click (TMJ) (Rt Lt)	C	P	N/A	Digestive problems	C	P	N/A
Itching	C	P	N/A	Head seems too heavy	C	P	N/A	Excessive gas	C	P	N/A
Bruise easily	C	P	N/A	Head and shoulders feel tired	C	P	N/A	Belching/bloating after meals	C	P	N/A
Cancer	C	P	N/A	Difficulty in excessive (standing, sitting,	C	P	N/A	Heartburn	C	P	N/A
Frequent colds/flu	C	P	N/A	riding, bending, lifting, twisting, household				Ulcers	C	P	N/A
				duties)				Diarrhea/Constipation	C	P	N/A
Nervous	C	P	N/A	Shoulder pain (Rt Lt)	C	P	N/A	Colon trouble	C	P	N/A
Tension	C	P	N/A	Ringing in ears (Rt Lt)	C	P	N/A	Hemorrhoids	C	P	N/A
Depression	C	P	N/A	Hearing loss (Rt Lt)	C	P	N/A	Prostate problems	C	P	N/A
Irritability	C	P	N/A	Fainting	C	P	N/A	Breast lumps, soreness, discharge	C	P	N/A
Anemia	C	P	N/A	Loss of balance	C	P	N/A	Pregnant (now)	C	P	N/A
Excess sweating	C	P	N/A	Blurred or double vision (Rt Lt)	C	P	N/A	Bed wetting	C	P	N/A
Tremors	C	P	N/A	Upper back pain or stiffness	C	P	N/A	Ear infections	C	P	N/A
Light bothers eyes	C	P	N/A	Mid back pain or stiffness	C	P	N/A	Hepatitis	C	P	N/A
Allergies	C	P	N/A	Low back pain or stiffness	C	P	N/A	Venereal disease	C	P	N/A
Sinus problems	C	P	N/A	Numbness, tingling of pain in buttocks,	C	P	N/A	AIDS/ARC	C	P	N/A
Light headed upon rising	C	P	N/A	thighs, legs, feet, toes							
Under stress	C	P	N/A	Pain with cough, sneeze, or strain at stools	C	P	N/A				
Crave sweets or salt	C	P	N/A	Dizziness	C	P	N/A				
Eating disorder	C	P	N/A	Hip pain (Rt Lt)	C	P	N/A				
Dyslexia	C	P	N/A	Foot trouble (Rt Lt)	C	P	N/A				
Mood changes	C	P	N/A	Chest pain	C	P	N/A				
Trouble sleeping	C	P	N/A	Asthma	C	P	N/A				
Trouble concentrating	C	P	N/A								

Kelly Chiropractic
Clinton Twp., MI

Family history of:
Arthritis Y N Cancer Y N Diabetes Y N Heart Disease Y N Back Problems Y N Scoliosis Y N
Any others, please list: _____
_____
_____
Please list all surgeries and dates performed: _____
Please list all drugs you are currently taking (prescription and non-prescription): _____
_____
Have you seen any other doctors for this condition? Yes No If yes, what doctor, what was done and for how long?
_____
Are you wearing heal lifts? Yes No Arch supports? Yes No
Last dental appointment: _____ Last eye exam: _____Last physical exam: _____
Please list all vitamins and supplements you are currently taking: _____

Habits:	Alcohol	Coffee	Tobacco	Exercise	Sleep	Appetite	Recreation	Sweets
Heavy								
Moderate								
Light								
None								

Signature: _____

PLEASE DO NOT WRITE BELOW THIS LINE. DOCTOR USE ONLY

_____

MAJOR COMPLAINTS:

Location: _____
Date of onset and duration: _____
Mode of onset (fall, accident, chronic): _____
_____
What type of pain (sharp, burning, achy): _____
Symptomology: _____
Constant, intermittent, recurrent: _____

PREVIOUS DX AND CARE:

Doctor or clinic: _____
Address: _____
DX: _____
Treatment: _____
Result: _____
Activities: _____ Interfere: Yes No

PREVIOUS HISTORY OF INJURY OR ACCIDENTS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Kelly Chiropractic

Terms of Acceptance

When a person seeks Chiropractic health care and we accept the person as a patient, it is essential that we are both working toward the same objective.

Chiropractic has only one goal. It is important that a patient understands both the objective and the method that will be used to attain the goal. This will prevent any misunderstanding, confusion, or disappointment.

The Chiropractic goal is to locate and correct/reduce vertebral subluxations by the use of Chiropractic Spinal adjustments, so that the body is better able to function normally and restore health.

HEALTH: a state of optimal physical, mental, and social wellbeing, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: a misalignment of one or more vertebrae in the spinal column which causes alterations of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

SPINAL ADJUSTMENT: a chiropractic spinal adjustment is the specific application of forces to facilitate the body's correction/reduction of vertebral subluxations.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of our chiropractic spinal examination, we encounter non-chiropractic unusual findings, we will make you aware of those findings. If you desire advice, diagnosis or treatment for those findings, we recommend that you seek the services of a health care provider who specializes in that area.

We do not offer to treat any disease. We do not offer advice regarding treatment prescribed by others. Our objective is to correct/reduce an interference to the expression of the body's innate wisdom. Our method is by specific chiropractic spinal adjustments to correct/reduce vertebral subluxations. Some vertebral subluxations are correctable. Some are reducible. Some are neither correctable nor reducible.

If chiropractic spinal adjustments are improperly provided, vertebral subluxations may be increased and there is a risk of increased malfunction within the body.

All questions regarding Dr. Kelly's objectives pertaining to my care at Kelly Chiropractic have been answered to my complete satisfaction.

I hereby accept and authorize the making of spinal and paraspinal x-ray films, a chiropractic spinal examination and initiation of chiropractic care based upon Dr. Kelly's interpretation.

I, _____, have read and fully understand the above statements.

_____Signature _____ Date

Kelly Chiropractic

Insurance Assignment Program

It is our desire to assist our patients whenever possible. The following insurance assignment allows you to receive the care you need, without undue financial strain. However, your insurance plan is an agreement between you and your insurer, not between your insurer and our office.

Billing for insurance payment is a service provided by this office. We reserve the right to withdraw this service at any time.

All insurance deductibles and co-payments are the responsibility of the patient. When determined, if applicable, you will be informed of the amounts.

In the event that your insurer does not pay us within 30 days, we will rebill your claim. If the claim is not paid within 60 days of the initial billing, we will send you a statement in which you are responsible to pay. You can seek reimbursement through your insurance company on your own.

If you have more than one insurance company or change insurance companies please let us know.

Although your insurer is directed to make payment to this office, if you receive payment from your insurer please bring the check to our office.

This office cannot be certain that your insurance company will pay for your care. Insurance companies do not keep us informed of policy changes. We suggest that you personally contact your insurance your insurance carrier so that you understand the terms of your policy. Some insurers in the past have provided us with misinformation. In the event that your insurer rejects or disputes your claim, it is the patient's responsibility to pay for services performed and pursue reimbursement from the insurance company.

<u>Authorization to Pay Doctor</u>

Independent of my insurer _____administrative policies or procedures, I hereby specify and authorize (or photocopy thereof) that payment is made by check and mailed directly to:

Dr. Charles Kelly or Dr. Donna Kelly (dependent upon physician)
36410 Garfield Road, Clinton Township, MI 48035, the benefits payable for services tendered on my behalf. I authorize the release of any information necessary to process claims on my behalf. In making this assignment, I understand and agree that any unpaid balances not covered by my insurance company will be paid by me. This authorization shall remain in effect until full payment is received at this office for all services rendered at Kelly Chiropractic. I agree that any collection actions can be undertaken Macomb County of the state of Michigan. If care is terminated, without Dr. Kelly's consent, any outstanding, unpaid charges are immediately due and payable.

Name (Print): _____

Signature: _____

Date: _____

Witness: _____