RESTORE LIFE CHIROPRACTIC
JOE D. KENNEDY, D.C.

1090 SCHOOLHOUSE RD., #500
HASLET, TX 76052
(817) 251-1637

PATIENT INFORMATION---Please Print

GENERAL INFORMATION

Patient Last Name ______________________________ First Name ______________________
Address ______________________________ Care of ______________________
(Parent or financially responsible person)
City ____________________ State ________ Zip Code ________ Phone (Home) ______________
Driver's License # ______________________ No. Children _____ Phone (Work) ______________
Email Address ____________________ Cell Phone ______________

Sex M F	Married Single Widowed Divorced	Age	Date of Birth / /	Social Security Number -- --

Employer's Name ______________________________
Address ______________________________
City ______________ State ________ Zip Code__________
Phone ______________ Occupation ______________

Spouse's Name __________ Spouse's Employer __________
Spouse's Date of Birth ______________

EMPLOYED
Full Time Part Time
Retired Not Employed

STUDENT
Full Time Part Time
Non-Student

REFERRED BY: ______________________________

INSURANCE INFORMATION

Primary Insurance Company Name ______________________ Insured's Name ______________ ID/Membership # ______________ Policy/Group # ______________ Provider Customer Service Phone __________	***Complete only if patient is not the insured*** Patient's Relationship to Insured ______________ Insured's Date of Birth _____/_____/______ Insured's Employer ______________
Secondary Insurance Company Name ______________________ Insured's Name ______________ ID/Membership # ______________ Policy/Group # ______________ Provider Customer Service Phone __________	***Complete only if patient is not the insured*** Patient's Relationship to Insured ______________ Insured's Date of Birth _____/_____/_____ Insured's Employer ______________

Are you seeing the Doctor today due to a:
(If yes, please inform the front desk)
Work-Related Injury? Yes___ No ___ Date of Injury __________

Auto Accident? Yes ___ No ___ Date of Injury __________

RELEASE AND ASSIGNMENT

I agree to treatment by my doctor and such persons of the doctor's choosing, which may include interns, preceptors, Chiropractic Assistants, etc and hereby provide my consent for treatment.
Patient's Signature ______________________________ Date ______________

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my chiropractor.
Patient's Signature ______________________________ Date ______________

I understand that Restore Life Chiropractic will prepare any necessary forms to assist me in submitting claims to my insurance provider and credit my account when payment is received. However, I clearly understand that all services rendered to me are charged to me and I am responsible for payment unless other arrangements are made.
Patient's Signature ______________________________ Date ______________

PATIENT HISTORY/EXAMINATION FORM

________________________**Complete ALL questions below** ____________________________

1. What are your **major complaint(s)/illnesses?**____
____

2. What are your **minor complaint(s)/illnesses?**____
____

3. How **long** have you been experiencing your major complaint? □ Days □ Weeks □ Months □ Years

Mechanism of Injury

4. What was the **cause** of your major complaint that brought you into the office today (how did it happen)?
____
____

5. **When** did you first experience your major complaint? ____

6. What have you done **prior** to coming to this office to treat your major and minor complaints?
____
____

7. When do you **notice** your complaint or complaints the most? □ AM □ PM □ BOTH

8. How long does it last? __________Minutes __________Hours

9. What makes it feel **worse**? □ Sitting □ Standing □ Lying □ Activity □ Other______________

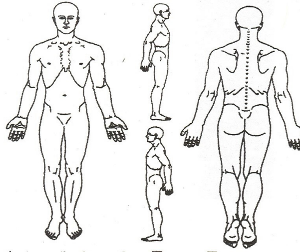
10. What makes it feel **better**? □ Sitting □ Standing □ Lying □ Activity □ Drugs □ Other______________

11. What best describes the character and quality of your major illness or pain?

A: ache B: burning pain T: tingling N: numbness S: sharp K: cramping D: dull pain

12. Have you ever had this problem in the past? □ Yes □ No

13. On the diagram below, please **show** where you are experiencing all of your present complaints using the following letters: A: ache B: burning pain T: tingling N: numbness S: sharp K: cramping D: dull pain



14. On the scale below, please **circle** the **severity and intensity** of your **main complaint** (at its' worst):

None	Slight		Mild		Moderate		Severe		
1	2	3	4	5	6	7	8	9	10

15. On the scale below, please **circle** the **percentage of time** you experience your **main complaint**:

Occasional			Intermittent			Frequent			Constant
10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

16. Does your pain radiate? _____Y ______N Where does it radiate to? _________________________________

Signature ____ **Date** _____________________________

Patient History
Please check (x) all present and past symptoms.

HEAD:
___Headache
___Sinus
___Entire head
___Back of head
___Forehead
___Temples
___Migraine
___Loss of memory
___Light-headed
___Fainting
___Light bothers eyes
___Blurred vision
___Double vision
___Loss of vision
___Loss of balance
___Loss of taste
___Loss of hearing
___Dizziness
___Pain in ears
___Ringing or noises in ears

NECK:
___Pain in neck
___Sharp
___Dull
___Ache
___Neck pain with movement
___Forward
___Backward
___Turning (L) (R)
___Bending (L) (R)
___Pinched nerve in neck
___Neck feels out of place
___Muscle spasms in neck
___Grinding sounds in neck
___Popping sounds in neck

SHOULDERS:
___Pain in joint (L) (R)
___Pain across shoulders
___Arthritis (L) (R)
___Can't raise arm
___Above shoulder level
___Over head
___Tension in shoulders
___Pinched nerve in shoulder (L) (R)
___Muscle spasms in shoulder

ARMS AND HANDS:
___Pain in arm
___Tennis elbow
___Pain in hands/fingers (L) (R)
___Pins and needles sensation (L)(R)
___Numbness (L) (R)
___Hands cold
___Loss of grip strength
___Sore/swollen joints in fingers

MIDBACK:
___Mid-back pain
___Pain between shoulder blades
___Sharp stabbing
___Dull ache
___Muscle spasms

CHEST:
___Chest pain
___Shortness of breath
___Rib pain
___Breast pain
___Irregular heartbeat

ABDOMEN:
___Nervous stomach
___Foods can't eat___________
___Nausea
___Gas
___Constipation
___Diarrhea
___Hemorrhoids

LOW BACK:
___Lower back pain
___Sharp
___Dull
___Ache
Location:
___Upper lumbar
___Lower lumbar
___Hip
___Low back pain is worse when
___Working
___Lifting
___Stooping
___Standing
___Sitting
___Bending
___Coughing
___Lying down
___Walking
___Pain relieved when_________
___Slipped disc
___Low back feels out of place
___Muscle spasms

HIPS, LEGS & FEET:
___Pain in buttocks (L) (R)
___Pain in hip joint (L) (R)
___Pain down leg (L) (R)
___Knee pain (L) (R)
___Outside
___Inside
___Leg cramps
___Feet cramps
___Pins and needles in legs
___Numbness in legs/feet
___Swelling in legs/feet

WOMEN ONLY:
___Menstrual pain
___Cramping
___Irregularity
___Cycle ___Days
___Birth control __________type
___Hysterectomy
___Tumors/Cancer_________
___Discharge
___Menopause
___Abortions
___Are you pregnant

MEN ONLY:
___Urinary frequency
___Difficulty urination
___Night urination
___Prostate swelling

GENERAL:
___Nervousness
___Irritable
___Depressed
___Fatigue
___Run-down feeling
___Normal sleep _______hrs
___Loss of sleep
___Loss of weight _______lbs
___Weight gain _________ lbs
___Coffee _______cups/day
___Tea _______cups/day
___Cigarettes _______pack/day
___Diabetes
___Hypoglycemia

OTHER ____________________________
____

Medications: ________________________
____
____
____

Signature: ____ **Date:** __________________________

POLICIES

1. All first visit charges are payable when services are rendered.

2. The fee paid for treatment x-rays is for analysis only. X-rays are the property of this office and are used for treatment purposes. A copy of your x-rays may be requested *today for only $20*. A copy of your x-rays requested after today can be obtained for only $50.

3. Method of payment you plan to use to take care of today's charges? (Please check one choice)

☐ CASH ☐ CHECK ☐ VISA/MASTERCARD/DISCOVER

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Restore Life Chiropractic Center will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Restore Chiropractic Center will be credited to my account upon receipt. **However**, I clearly understand and agree that all my services rendered me are charged directly to me and that I am responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. If an account balance remains unpaid for three months or longer, a monthly interest fee of 2% will apply to account balance. I authorize Restore Chiropractic Center to obtain a credit report if deemed necessary.

Please Note:
This will be our only notice to you. Due to our efforts to keep costs down and control our outstanding accounts, all accounts over 30 days past due are subject to collection agency procedures and additional costs.

Patient Signature____ Date____________________

Guardian Signature Authorizing Care_____________________________________ Date____________________

EMERGENCY CONTACT INFORMATION: *[Please list someone OUTSIDE OF YOUR HOME---Thank you!!]*

In case of emergency, please notify____

Relationship____

Address ____
____
____

Phone # ____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion and disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

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

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ____ have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

____ ____________________
Signature Date

FEMALES ONLY:

Pregnancy Release
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period ________________________________.

____ ____________________
Signature Date

PATIENT PRIVACY NOTICE

Restore Life Chiropractic
1090 Schoolhouse Road #500 Haslet, TX 76052 (817) 729-1544
Joe D. Kennedy, D.C.

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Restore Life Chiropractic we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers communicating with you, but in our professional judgment we believe you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you would like further information about our privacy policies and practices please contact: Joe D. Kennedy, D.C.

This office utilizes an “open treatment” environment for ongoing patient care. “Open treatment” involves the possibility of other patients being seen in the same “treatment environment” at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within hearing of other patients and staff. A private, closed and confidential setting is provided for history taking, examinations, report of findings, etc. as determined by the doctor or staff. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted or use traction in an “open treatment” environment other arrangements will be made for you. This office also requests the presence of your spouse or significant other at your Doctor’s Report appointment for purposes of health education.

This notice is effective as of ______________________. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

______________________________	______________________________	______________
Printed Name	Signature	Date

AUTHORIZATION FORM

Restore Life Chiropractic
1090 Schoolhouse Road #500 Haslet, TX 76052 (817)729-1544
Joe D. Kennedy, D.C.

This office utilizes an "open treatment" environment for ongoing patient care. "Open treatment" involves the possibility of other patients being seen in the same "treatment environment" at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within hearing of other patients and staff. A private, closed and confidential setting is provided for history taking, examinations, report of findings, etc. as determined by the doctor or staff. The use of this format is intended to make your experience with our office the most efficient and productive and to further enhance your access to quality, principled chiropractic health care and health information. If you choose not to be adjusted or use traction in an "open treatment" environment other arrangements will be made for you. Your decision will have no adverse affect on your care with Restore Life Chiropractic or your relationship with our staff. This office also requests the presence of your spouse or significant other at your Doctor's Report appointment for purposes of health education.

We are requesting your authorization due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open treatment" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure and requesting your authorization.

Additionally this office may use your name, address and/or telephone number for the purposes of contacting you to remind you about scheduled appointments, reevaluations, other appointment issues, newsletters, flyers, birthday cards, thank you cards, health related meetings, and/or Advanced talks/classes. During the course of your care with Restore Life Chiropractic it may be the desire of our office to request the use of your name for our referral/thank you board(s) and/or to obtain a patient testimonial or patient photo for the purpose of promoting chiropractic.

This authorization may be revoked by you, the patient, at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

Your signature indicates your authorization of the above described.

____
Printed Name

____ ____________________
Signature Date

INFORMED CONSENT FOR TREATMENT

Physicians and other health care providers are required to obtain your informed consent before starting treatment.

I ______________________________________ do hereby give my consent to the performance of chiropractic treatment that may consist of manipulations/adjustments, physical medicine, exercises and traction. I understand that the manipulations/adjustments will involve movement of the joints and soft tissues that is considered to be one of the safest and most effective forms of therapy for musculoskeletal problems.

I am aware that there are possible risks/complications associated with my treatment. Tests have been performed to minimize these risks. I freely assume the risks of treatment after having been informed of the possible risks/complications associated with my treatment as follows:

- Soreness: It is common to experience muscle soreness during treatment
- Uncomfortableness: Temporary symptoms (dizziness, nausea) can occur, but are rare.
- Fractures/Joint Injury: Underlying physical defects, deformities or pathologies (osteoporosis) may cause susceptibility to injury.
- C.V.A.: Cerebral vascular accidents from chiropractic adjustments are extremely rare.

Treatment Results

I understand there are benefits associated with treatment including decreased pain, improved mobility and function and reduced muscle spasms. However, I also understand there is no guarantee that I will achieve these benefits during my care, as the practice of medicine, including chiropractic, is not an exact science.

Alternative Treatment Available

Reasonable alternatives to treatment have been explained to me including rest, home therapy, exercises medication and possible surgery.

I agree to treatment by my doctor and such persons of the doctor's choosing, which may include interns, and hereby provide my informed consent for treatment.

I HAVE READ OR HAVE HAD READ TO ME THE ABOVE EXPLANATION OF CHIROPRACTIC TREATMENT. ANY QUESTIONS REGARDING TREATMENT HAVE BEEN ANSWERED TO MY SATISFACTION.

____ ______________________

Patient Signature Date

____ ______________________

Parent/Guardian Signature (if minor) Date

Patient Status At Time Of Consent:

( ) Of Legal Age
( ) Oriented x3
( ) Coherent/Lucid
( ) Proficient English
( ) Assisted by Interpreter

( ) Medicated, but Unimpaired
( ) Denies Use of Alcohol or Recreational Drugs Prior to Consent
( ) Unable to Give Legal Consent
( ) Consent Given Via Legal Guardian

I certify that this form accurately reflects the patient's status during the informed consent process.

____ ____________________

Doctor/Staff Signature Date

Restore Life Chiropractic
Joe D. Kennedy, D.C. 1090 Schoolhouse Road #500 Haslet, TX 76052