KATO FAMILY CHIROPRACTIC
99 Navaho Ave Ste 110, Mankato, MN 56001
Phone: (507)594-9100 Fax: (256)291-0874

Patient Intake Form

Patient Information

Full Name: _____ Date: _____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Female: _____ Male: _____

Social Security Number: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

I prefer to receive calls at (circle) Home/Work/Cell

I am(circle)UnderAge18/Single/Married/Divorced/Widowed/Separated

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Payment Information

Person Responsible for Payment: _____

Social Security Number: _____ Phone: _____ Date of Birth: _____

Insurance Information

Do you have health insurance? _____ Yes _____ No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release *- By signing below, I authorize [clinic name] to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to [clinic name] and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signed _____ Date _____

KATO FAMILY CHIROPRACTIC
99 Navaho Ave Ste 110, Mankato, MN 56001
Phone: (507)594-9100 Fax: (256)291-0874

Health Questionnaire

Patient Information

Date: _____

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

List all prescription, non prescription medications and other supplements you take as well as the associated condition:

_____

_____

_____

List any surgeries or hospitalizations you have had complete with the month and year for each:

_____

_____

_____

List anything you are allergic to: _____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

_____

_____

_____

Do you exercise? □ Yes □ No Hours per week _____What activity(s)? _____

_____

Are you dieting? □ Yes □ No Since:_____ Do you smoke? □ Yes □ No _____packs per day.

How many years have you been smoking? _____ Do you drink alcoholic beverages? □ Yes □ No _____drinks per day.

Do you wear? □ Heal lifts □ Arch supports □ Prescription Orthotics

For women: Are you pregnant or nursing? □ Yes □ No If pregnant, How many weeks? _____

Date of last menstrual period: _____

KATO FAMILY CHIROPRACTIC
99 Navaho Ave Ste 110, Mankato, MN 56001
Phone: (507)594-9100 Fax: (256)291-0874

Medical History

Describe the reason(s) for your doctor visit today:

Are you here because of an accident? _____What type? _____

When did your symptoms start? _____ How did your symptoms begin? _____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities?_____

Have you experienced these symptoms in the past?_____

History of Treatment

Primary care physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? ___Yes ____ No

Have you seen a chiropractor before? ____Yes ____ No Who referred you to us? _____

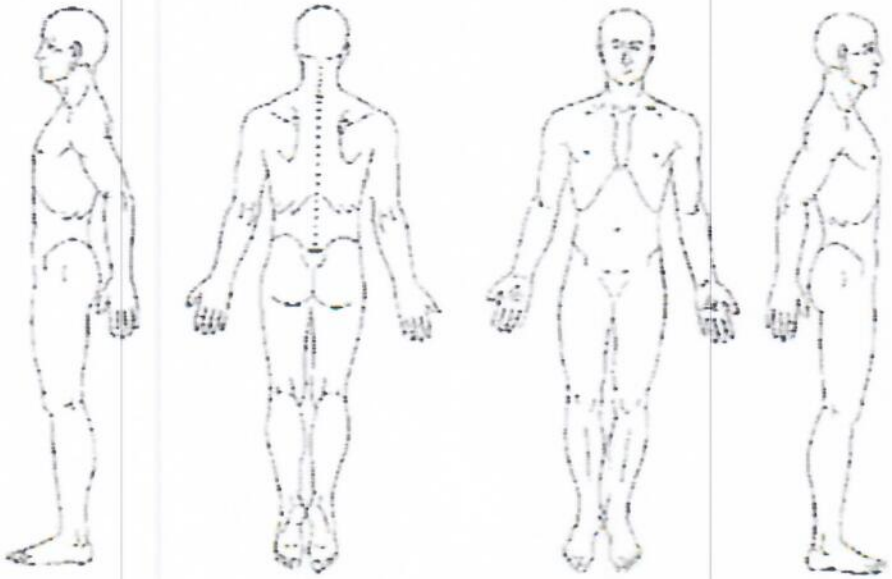
Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _____

KATO FAMILY CHIROPRACTIC
99 Navaho Ave Ste 110, Mankato, MN 56001
Phone: (507)594-9100 Fax: (256)291-0874

Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



Left Back Front Right

On a scale of one to ten how intense are your symptoms? Not intense ⓪①②③④⑤⑥⑦⑧⑨⑩ Unbearable

KATO FAMILY CHIROPRACTIC
99 Navaho Ave Ste 110, Mankato, MN 56001
Phone: (507)594-9100 Fax: (256)291-0874

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
O	O	Abdominal Pain	O	O	Elbow/upper arm pain	O	O	Liver/Gall Bladder Disorder
O	O	Abnormal Weight gain/loss	O	O	Epilepsy	O	O	Loss of Bladder Control
O	O	Allergies Headache	O	O	Excessive thirst	O	O	Low back pain
O	O	Angina	O	O	Frequent Urination	O	O	Mid back pain
O	O	Ankle/foot pain	O	O	General Fatigue	O	O	Neck pain
O	O	Arthritis	O	O	Hand pain	O	O	Painful Urination
O	O	Asthma	O	O	Heart attack	O	O	Prostate Problems
O	O	Bladder Infection	O	O	Hepatitis	O	O	Shoulder pain
O	O	Birth Control Pills	O	O	High blood pressure	O	O	Smoking/tobacco Use
O	O	Cancer	O	O	Hip/upper leg pain	O	O	Stroke
O	O	Chest Pains	O	O	HIV/AIDS	O	O	Systematic Lupus
O	O	Chronic Sinusitis	O	O	Hormone Therapy	O	O	Thoracic Outlet Syndrome
O	O	Depression	O	O	Jaw pain	O	O	Tumor
O	O	Dermatitis/Eczema	O	O	Joint swelling/stiffness	O	O	Ulcer
O	O	Dizziness	O	O	Kidney Stones	O	O	Upper back pain
O	O	Drug/Alcohol Use	O	O	Knee/lower leg pain	O	O	Wrist pain

Additional comments you would like the doctor to know: _____

_____

_____

_____

Patient's signature: _____ **Doctor's signature:** _____

Kato Family Chiropractic

PATIENT CONSENT FOR CHIROPRACTIC TREATMENT

PATIENT NAME: _____ MED REC # _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask your Doctor any questions that you have about the information below. You can ask questions at any time before, during, or after your treatment.

The nature of chiropractic adjustment: The primary treatment your Doctors of Chiropractic uses is spinal manipulative therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click", much as you have experienced when you "crack" your own knuckles. You may also feel a sense of movement.

Examination and Treatment: In addition to spinal manipulation, we *may* use a variety of other therapies and examination procedures. As a part of the analysis, examination, and treatment, you are consenting to the following additional procedures:

____spinal manipulative therapy	____palpation	____vital signs
____orthopedic testing	____range of motion testing	____basic neurological exam
____muscle strength testing	____ultrasound	____radiographic studies
____Rehabilitation/Core strengthening	____nutritional therapy	
____mechanical traction/flexion distraction	____Other(please explain)_____	

Provider will explain these procedures to you and answer any questions you have about them.

The material risks inherent in chiropractic adjustment: Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care. However, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.

Chiropractic is a safe and comfortable form of health care for most people. If a potential risk is identified, you will be informed and offered either treatment or a referral to the appropriate health care specialist for evaluation and care.

The probability of risks occurring:

Soreness: It is not uncommon to experience some localized soreness following a manipulation. This type of soreness is usually minor and occurs most often following the initial few visits. It is similar to the soreness you may experience after exercise.

Fracture: Fractures caused from spinal manipulations are extremely rare. It is so rare that an actual number of incidences per manipulation have never been determined. Patients suffering from bone weakening conditions like Osteoporosis are in a higher risk category. Alternative forms of spinal manipulation may be utilized for this type of patient.

Ruptured/Herniated Disc: There have been some reports of herniated or ruptured discs caused by spinal manipulations. Alternative spinal adjusting methods are often utilized to minimize the risk and help the patient recover from serious disc-related pain.

TIA/Stroke: According to the literature, possible neurological complications can arise in 1 per 1-8 million office visits or 1 per 2-5.85 million adjustments. Screening tests are performed when necessary to rule out high-risk patients. Alternative spinal adjusting is utilized when necessary to minimize any potential risks.

Other complications: These include but are not limited to: dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The availability of other treatment options: Other treatment options for your condition may include:

Self-administered, over-the-counter medications
Medical care and prescription drugs, such as anti-inflammatories, muscle relaxants, and pain killers
Hospitalization/Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are also risks and benefits with each one of those options and you may wish to discuss these with your primary medical physician.

The risks and dangers associated with remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Notices of Privacy Practices: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in the Notice of Privacy Practices. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

Consent to Release of Information:
In accordance with Minnesota Statutes § 144.335, I consent to the release by my provider of my health records and medical information about me to physicians, providers, and staff as necessary for treatment, to insurers as necessary to receive payment for services, and to third parties for purposes of reviewing quality of care and for health care operations (so long as the release is in compliance with applicable law), including releases for internal or external audits, research and quality assurance, or licensing/accreditation purposes.

I give my permission to my provider to communicate information about me to those people involved in my care for the purpose of my treatment as designated in my medical record.

I give permission for my provider to communicate with me regarding my medical care, such as results of tests/reports through voicemail messages via the phone numbers I have supplied in my medical record.

In order to assure proper quality and continuity of care, I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, or third party administrators to share my health records and information obtained from my health care provider or any other provider, with my health care provider, other providers from whom I have received services, or any other payer, payer network organization, or third party administrators as needed for payment and health care operations.
I understand this Consent to Release of Information does not expire unless I revoke it or provide a specific expiration date here: _____

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. BY SIGNING BELOW, I CONSENT TO ALL OF THE USES AND DISCLOSURES ABOVE, AND I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES.
I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my provider and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I do not expect the doctor to be able to anticipate and explain all the risks and complications. Having been informed of the known risks, I hereby give my consent to that treatment. I intend this consent to apply to all of my present and future chiropractic care.

_____	_____	_____
Date	Signature of patient or authorized person	Authority to act on behalf of patient