KETZ CHIROPRACTIC

5905 Lake Otis Pkwy Anchorage, AK 99507 907-562-5500

New Patient Form

Patient Name: _____ Date:_____

Mailing Address: _____City: _____State _____Zip_____

Home Phone: _____Cell Phone _____Work Phone_____

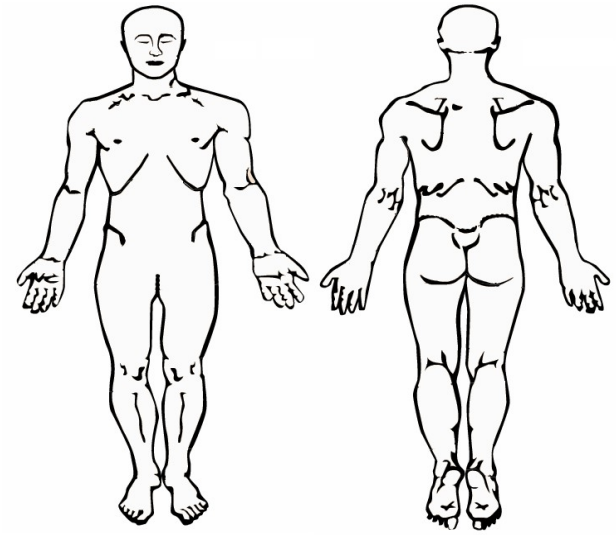
What type of case is responsible for todays problem? □ Auto Accident □ Work Injury □ Personal Insurance □ Other

Are you personally insured? □ Yes □ No Are we going to be billing your personal insurance? □ Yes □ No

Insurance Company: _____

Policy ID: _____ Group No.: _____

Indicate on the drawings where you have symptoms:



You will have to answer questions about each area indicated above:

Neck

How often do you experience symptoms?

□ Constant (76-100%) □ Frequent (51-75%) □ Intermittantly (26-50%) □ Occasional (1-25%)

How would you describe the type of pain?

□ Sharp □ Sharp with motion □ Stabbing □ Dull □ Throbbing □ Stinging

□ Shooting □ Shooting with motion □ Burning □ Stabbing □ Aching □ Pulling

Circle the number that is your pain level. (10 is the worst)

0 1 2 3 4 5 6 7 8 9 10

Are your symptoms □ Getting worse □ Staying the same □ Getting better

How long have you had this problem?_____

How do you think your problem began?_____

Where else have you been seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER Physician □ Orthopedist

□ Massage Therapist □ Physical Therapist □ Other_____ □ No One

What makes it worse?

□ Looking up □ Sleeping □ Working □ Driving □ Working on computer □ Bending

□ Looking down □ Running □ Sports □ Walking □ Sitting □ Other_____

What makes it feel better? _____

What does it prevent you from doing? _____

Mid Back

How often do you experience symptoms?

□ Constant (76-100%) □ Frequent (51-75%) □ Intermittently (26-50%) □ Occasionally (1-25%)

How would you describe the type of pain?

□ Sharp □ Sharp with motion □ Stabbing □ Dull □ Throbbing □ Stinging

□ Shooting □ Shooting with motion □ Burning □ Stabbing □ Aching □ Pulling

Circle the number that is your pain level. (10 is the worst)

0 1 2 3 4 5 6 7 8 9 10

Are your symptoms □ Getting worse □ Staying the same □ Getting better

How long have you had this problem?_____

How do you think your problem began?_____

Where else have you been seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER Physician □ Orthopedist

□ Massage Therapist □ Physical Therapist □ Other_____ □ No One

What makes it worse?

□ Looking up □ Sleeping □ Working □ Driving □ Working on computer □ Bending

□ Looking down □ Running □ Sports □ Walking □ Sitting □ Other_____

What makes it feel better? _____

What does it prevent you from doing? _____

Low Back

How often do you experience symptoms?

□ Constant (76-100%) □ Frequent (51-75%) □ Intermittently (26-50%) □ Occasionally (1-25%)

How would you describe the type of pain?

□ Sharp □ Sharp with motion □ Stabbing □ Dull □ Throbbing □ Stinging

□ Shooting □ Shooting with motion □ Burning □ Stabbing □ Aching □ Pulling

Circle the number that is your pain level. (10 is the worst)

0 1 2 3 4 5 6 7 8 9 10

Are your symptoms □ Getting worse □ Staying the same □ Getting better

How long have you had this problem?_____

How do you think your problem began?_____

Where else have you been seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER Physician □ Orthopedist

□ Massage Therapist □ Physical Therapist □ Other_____ □ No One

What makes it worse?

□ Looking up □ Sleeping □ Working □ Driving □ Working on computer □ Bending

□ Looking down □ Running □ Sports □ Walking □ Sitting □ Other_____

What makes it feel better? _____

What does it prevent you from doing?_____

What is your: Age_____ DOB: _____ Gender M / F

Marital status: □ S □ M □ D □ W How many children? _____ Name of spouse/parent _____

Your Email _____ Emergency Contact: _____

Occupation _____ Employer _____

How would your rate your overall health? □ Excellent □ Very Good □ Good □ Fair □ Poor

What type of exercise do you do? □ Strenuous □ Moderate □ Light □ None

Do you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus

□ Heart problems □ Cancer □ ALS

Put a check if you have any of the following conditions. Please check "past" or "present" for each.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High blood pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart attack	□	□	Excessive Thirst
□	□	Upper back pain	□	□	Chest pains	□	□	Frequent Urination
□	□	Mid back pain	□	□	Stroke	□	□	Smoking/tobacco use
□	□	Low back pain	□	□	Angina	□	□	Drug/Alcohol Dependency
□	□	Shoulder pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Painful urination	□	□	Epilepsy
□	□	Hand pain	□	□	Loss of bladder control	□	□	Dermatitis/eczema
□	□	Hip pain	□	□	Prostate problems	□	□	HIV/AIDS
□	□	Upper leg pain	□	□	Abnormal weight gain	□	□	Abnormal weight loss
□	□	Knee pain	□	□	Ulcer	□	□	Hepatitis
□	□	Ankle/foot pain	□	□	Liver/gall bladder prob	□		**Female Only**
□	□	Jaw pain	□	□	General fatigue	□	□	BCP
□	□	Joint stiffness	□	□	Visual disturbances	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Dizziness	□	□	Pregnancy

List all prescription medications: _____

List all over the counter medications:_____

List all surgical procedures: _____

Have you ever been hospitalized? □ Yes □ No If yes why? _____

Do you have any past significant trauma? □ Yes □ No _____

Have you ever been to a Chiropractor before? □ Yes □ No How long? _____

In exchange for Ketz Chiropractic LLC forbearance from collecting all amounts owed by me for services rendered at the time of provision of service, I hereby assign my rights to the clinic as follows: I understand and agree health and accident insurance are an agreement between an insurance company or carrier and myself. Furthermore, I understand that the clinic will prepare any necessary reports and forms provided by me to assist me, or my legal representative. In making collection from the insurance company or carrier, I hear by specifically authorize the release of any information concerning me to my insurance carriers, insurance carriers of persons or entities responsible for my injuries, my employer, claims adjustor responsible for claims filed by me, administrative agencies, the Alaska Workers Compensation Board, and my attorneys. To the extent of my unpaid bill to the clinic, I hereby irrevocably assign to said clinic that at the time of final judgement, and final disposition of settlement this assignment shall have priority over all others not entitled by law to superior priority.

I specifically request that any amount authorized to be paid to my by an insurance company, employer, or legal representative shall be paid directly to the clinic, and will be credited to my account upon receipt. If the payment is insufficient to pay for all my indebtedness, I will remain liable to Ketz Chiropractic, LLC for the balance, including financing charges and collection expenses.

I clearly understand and agree that all services rendered to me, whether I have health or accident insurance or not, charged directly to me, and that I am personally responsible for payment and, unless arrangements are made, said payments are immediately due and payable at the time of visit. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In such event, I agree that this assignment will remain in effect until all sums owed Ketz Chiropractic LLC are fully paid.

Patient Signature / Legal guardian _____Date _____

Social Security number: _____ - _____ - _____ (needed if we are billing insurance)

On the job injury (Worker's Compensation)

Employer Name: _____Employer Address: _____

Contact person: _____Date Injured _____ Hour_____

How did the injury occur: _____

Did you go to the Emergency Room? □ Yes □ No If yes, where? _____

Have you lost any days off work? □ Yes □ No If yes, when? _____

Did you report this injury to your foreman or employer? □ Yes □ No

Auto Accident

Date of accident _____ Hour _____am / pm

Name of insurance company you wish to receive billing for payment: _____

Adjuster: _____ Claim No. _____

Address: _____ Phone _____

Have they authorized payment for medical/chiropractic expenses? □ Yes □ No

Have you been contacted by an insurance adjustor representative regarding this claim? □ Yes □ No

Do you have med-pay on your own insurance? □ Yes □ No

Did you injuries occur while driving on the job? □ Yes □ No

Where are you hurting as a result of this accident? _____

Have you lost any days off work? □ Yes □ No Dates:_____ Date last worked _____

Was a police report filled out? □ Yes □ No

Do you have an attorney that has advised you on this case? □ Yes □ No

Attorneys name: _____ Phone No. _____

Location of accident; _____

Were you the: □ Driver □ Front passenger □ Rear passenger

Were you struck from: □ Behind □ Front □ Right side □ Left side

Was your cars speed: □ stopped □ under 5mph □ 5-10mph □ 10-20mph □ 20-40mph □ over 40 mph

Speed of other car: □ stopped □ under 5mph □ 5-10mph □ 10-20mph □ 20-40mph □ over 40 mph

Did any part of your body strike the car? _____

Did you go to the Emergency Room? □ Yes □ No Where _____

Did you go in an ambulance? □ Yes □ No Did you drive yourself? □ Yes □ No

Did a friend take you? □ Yes □ No Were you hospitalized overnight? □ Yes □ No