KNIGHT FAMILY CHIROPRACTIC - CASE HISTORY/PATIENT INFORMATION

Name: ___________________________ Social Security #:__________________________
Date of Birth: ___________ Age: ____Cell Phone #:____________ Cell Carrier:_________
Address: __________________________ City: ___________ State: ____ Zip: ___________
Email address: __________________________ Occupation: _________________________
Employer: ________________________ Work phone #:____________________________
Spouse: ________________ Do you have children? If yes, how many?: ___ Ages______

How did you hear about our office? ________ If referred, by whom?_________________
Who's your primary physician? ____
Do we have your permission to update your physician about your care here? YES or NO

CURRENT COMPLAINT:
What brings you in? ____
Date symptoms appeared or accident happened: ____________________________________
Accident? ☐ Auto ☐ Work ☐ Other ____
How often are you experiencing it? ☐ Constant ☐ Daily ☐ Intermittent ☐ Night Only
How long does it last? ☐ All Day ☐ Few Hours ☐ Minutes
Describe your pain: ☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing ☐ Other________________
Is there anything you can do to relieve the problem? ☐ Yes ☐ No
If yes, describe: ____
If not, what have you tried that has not helped? ________________________________
What makes the problem worse? ☐ Standing ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting ☐ Other
____
Are there any other conditions or symptoms that may be related to your major symptom?
☐ Yes ☐ No If yes, describe: ____
Are there other unrelated health problems? ☐ Yes ☐ No
If yes, describe: ____
WOMEN: Are you pregnant/or possibly pregnant? ☐ Yes ☐ No ☐ Uncertain LMP: ___________

PAST MEDICAL HISTORY: Have you ever been diagnosed as having or have suffered from?
(Place a check mark by conditions that apply to you)

- Alcoholism
- Anxiety/Depression
- Arthritis RA or Osteo?
- Asthma
- Broken or Fractured Bones: ___________
- Cancer: _______________
- Circulatory/Bleeding
- Coughing Blood
- Diabetes 1 or 2
- Drug Addiction
- Gallbladder Issues
- Heart Disease
- High/Low Blood Press.
- HIV/AIDS
- Kidney Disease
- Liver Disease
- Lung Disease
- Mental Illness
- Osteoarthritis
- Pacemaker/Implant
- Seizures/Convulsions
- Stroke
- Ulcers/Digestion
- Other _____________________

Have you had any major **illnesses, injuries, falls, auto accidents or surgeries**? Women - include info about childbirth here:____________________________________

What medications, drugs, and vitamins are you taking?

____

Do you have any allergies: □ Yes □ No If yes, describe:

____

SOCIAL HISTORY:

Do you drink alcoholic beverages? □ Yes □ No If yes, How much per week? _____

Do you use any tobacco products? □ Yes □ No Vape? □ Yes □ No

Do you exercise? □ Yes -Frequency/Type_______________ □ No

FAMILY HISTORY:

Parents: Father: □ Living □ deceased / Mother: □ Living □ deceased

FAMILY DISEASES:

__ Tuberculosis	__ Arthritis	__ Kidney Disease	__ Heart Disease
__ Diabetes	__ Cancer	__ Liver Disease	__ Lung Disease
__ Stroke	__ Asthma	__ Mental Illness	__ Other ___________

______________________________________ ______________________________________

Patient/Guardian's Signature **Date**

CONSENT TO TREATMENT OF A MINOR

I hereby request and authorize Knight Family Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatments to my:

____

(indicate relationship to child)

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

______________________________________ ______________________________________

Patient's Printed Name **Patient's Signature**

______________________________________ ______________________________________

Signature of Parent or Guardian (if a minor) **Date**

______________________________________ ______________________________________

Doctor's Signature **Date**

KNIGHT FAMILY CHIROPRACTIC - FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is accepted under many insurance plans. Regardless of your coverage, we will suggest chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

If we are unable to verify your insurance benefits, we request that 100% of the first visit be paid at the time of the visit. After verification, we will credit your account for future visits. For future visits, we will discuss payment options to make your chiropractic care affordable.

Group or Individual Insurance

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers chiropractic, although most policies do provider coverage. The amount they pay varies from one policy to another. We will call to verify benefits on your insurance; however the benefits quoted to us by your insurance company are not a guarantee of payment.

As a courtesy to you, our office will complete any necessary insurance forms at no additional charge and file them with your insurance company to help you collect. It is to be understood and agreed that any service rendered is charged to you directly and you are personally responsible for payment of any non covered service, deductibles, or co-pays.

You may also pre-pay the full estimated amount due for your care and receive an appropriate courtesy/discount. If you choose to pay as you go, each visit, you may be required to pay at check in or have a credit card on file.

____

Patient's signature (or guardian if the patient is a minor) **Date**

____

Witness **Date**

HIPAA MEDICAL INFORMATION RELEASE FORM

Name:____

RELEASE OF INFORMATION - CHECK ONE:

☐ Information is **NOT** to be released to anyone.
☐ I authorize the release of information including the diagnosis, record; examination rendered to me and claims information. This information may be released to:
☐ Spouse: ____
☐ Children: ____
☐ Other: ____
This release of information will remain in effect until terminated by me in writing.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures established at Knight Family Chiropractic.

____

Signature of Patient **Date**

____

Witness **Date**

KNIGHT FAMILY CHIROPRACTIC - INFORMED CONSENT DOCUMENT

PATIENT NAME: ____

PLEASE READ THIS ENTIRE DOCUMENT PRIOR TO SIGNING IT. IT IS IMPORTANT THAT YOU UNDERSTAND THE INFORMATION CONTAINED IN THIS DOCUMENT.

The Nature of the Chiropractic Adjustment

The primary treatment used by Doctors of Chiropractic is spinal manipulative therapy. I will use that procedure when I treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and therapy, you are consenting to the following procedures:

Spinal manipulative therapy	Palpation	Vital signs
Range of motion testing	Orthopedic testing	Basic neurological testing
Muscle strength testing	Postural analysis testing	Hot/cold therapy
Radiographic studies	Other:	

The material risks inherent in a chiropractic adjustment

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 myelopathy, 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. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you feel you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research topic is inconclusive as to a specific incident of this complication occurring. If there is a casual relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants & pain killers
- Hospitalization
- Surgery

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

The risks and dangers attendant to 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.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Knight Family Chiropractic 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. Having been informed of the risks, I hereby give my consent to that treatment.

______________________________	______________________________
Patient's Printed Name	**Patient's Signature**
______________________________	______________________________
Signature of Parent or Guardian (if a minor)	**Date**
______________________________	______________________________
Doctor's Signature	**Date**

KNIGHT FAMILY CHIROPRACTIC
ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE/GROUP ACCIDENT AND HEALTH INSURANCE

Patient Name ____

Insured SS#/ID# ____

Claim/Group # ____

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

KNIGHT FAMILY CHIROPRACTIC

as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Knight Family Chiropractic 1108 W. White Street Anna, TX. 75409	Knight Family Chiropractic 3230 S. Eisenhower Pkwy. Denison, Texas 75020	Knight Family Chiropractic 1004 N. 19th Avenue Durant, OK. 74701	Knight Family Chiropractic 2021 N. Heritage Pkwy, Sherman, TX 75092

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

______________________________ ______________________________
Patient/Insured **Date**

______________________________ ______________________________
Witness **Date**

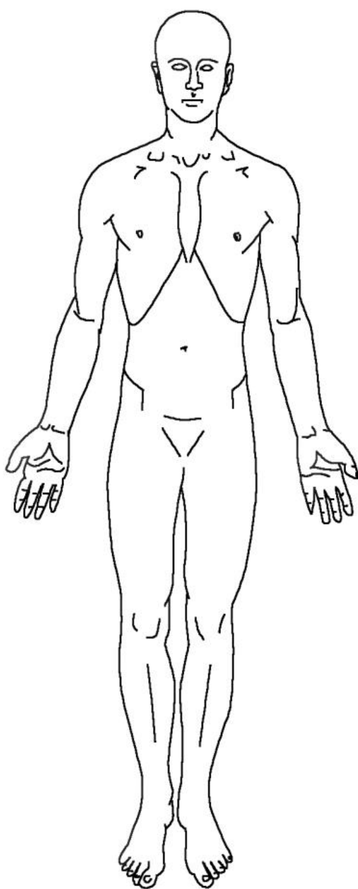
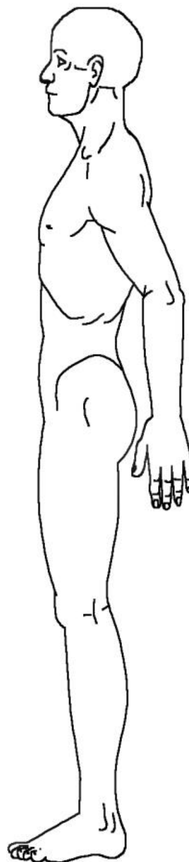
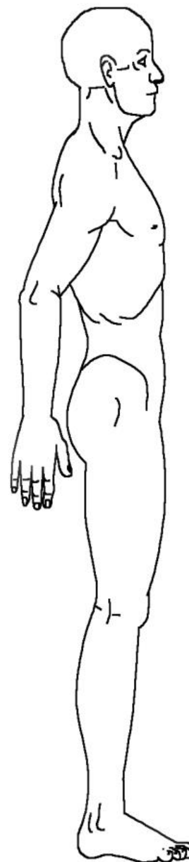
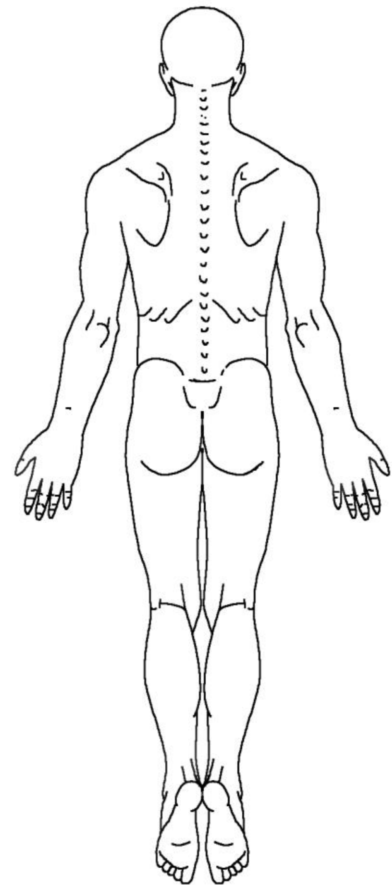
KNIGHT *Family*
CHIROPRACTIC

PAIN DRAWING

Name____**Date**______________

Using the following descriptive symbols, draw the location of your pain on body outlines below.
In addition, mark the level of your pain on the pain line at the bottom of the page.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
	====	OOOO	....	///////////	XXX

No Pain 1____10 Worst Possible Pain

Please make a slash through this line to indicate the level of your pain.

Patient Signature

____

KNIGHT *Family* CHIROPRACTIC

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name ____ Date __________________________

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

____

Examiner

OTHER COMMENTS:

____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

KNIGHT *Family* CHIROPRACTIC

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name ____ Date ___________________________

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

____
Examiner:

OTHER COMMENTS:

____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

KNIGHT FAMILY CHIROPRACTIC

www.DrKnight.net

CANCELLATION AND MISSED APPOINTMENT POLICY

**Our goal is to provide quality individualized chiropractic care in a timely manner.
In order to do this, we have to make sure we are adequately staffed and ready, especially during peak times.
"No-shows", and late cancellations inconvenience those individuals who need
access to care in a timely manner, and ultimately end up costing everyone more.
This policy enables us to better utilize available appointments for all of our patients in need of care.**

Cancellation of an Appointment

In order to be respectful of the needs of all of our patients, please be courteous and call us promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Various appointment times are in high demand, and your early cancellation will give another person the possibility to have access to timely care. If 24 hour notice is not given, you will be charged $30. This fee will need to be paid before future care is given.

How to Cancel Your Appointment

To cancel appointments, please call your treating office number. If you do not reach one of our staff members, you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time. Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24 hour advance notice. The $30 No-Show Fee will be accessed at that time.

CREDIT CARD: AMEX ✕ VISA ✕ MASTERCARD ✕ DISCOVER

CARDHOLDER NAME ______________________________

CARD # ______________________________

EXP. DATE ______________ SECURITY CODE: ____________

STATEMENT ADDRESS: ______________________________

____

I, ______________________________, have read, understand and agree to abide by the Cancellation Policy of Knight Family Chiropractic.

Patient Signature ______________________________ **Date** ______________

Staff Signature ______________________________ **Date** ______________