Kuna Chiropractic and Naturopathic Medicine
675 W. 4th Street, PO Box 215
Kuna, ID 83634
p 208.922.5057
f 208.922.5087

Patient Profile

Personal Information

Full Name: _____ Jr / Sr
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: _____ H / M / B Alternate Phone: _____ H / M / B

Birth Date: ___/___/___

Social Security Number #: ___-___-___

Gender: ☐ Male ☐ Female

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined ☐ Unknown/Unavailable
☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined ☐ Unknown/Unavailable

Prim. Language: ☐ Arabic ☐ Chinese ☐ English ☐ French ☐ German ☐ Greek ☐ Hebrew ☐ Italian
☐ Japanese ☐ Korean ☐ Spanish ☐ Vietnamese ☐ Declined ☐ Unknown/Unavailable
☐ Other _____

Email Address: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Time Zone: _____

Does your time zone participate in Daylight Savings Time? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Do you have any dependents? ☐ Yes ☐ No

Are you a full-time student? ☐ Yes ☐ No

Health Insurance? ☐ Yes ☐ No

Responsible Party: ☐ You ☐ Other (parent, spouse, etc.) _____

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Employer Form

Employer Information

Your Employment Status: ☐ Full Time ☐ Part Time ☐ Contract ☐ Not Employed ☐ Retired ☐ Student

Occupation or Title: _____

Employer Name: _____

Employer Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Employer Phone: _____ Ext. _____ Fax: _____

Start Date: ___/___/___ End Date: (If you are no longer working here.) ___/___/___

Your Employment Status: ☐ Full Time ☐ Part Time ☐ Contract ☐ Not Employed ☐ Retired ☐ Student

Occupation or Title: _____

Employer Name: _____

Employer Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Employer Phone: _____ Ext. _____ Fax: _____

Start Date: ___/___/___ End Date: (If you are no longer working here.) ___/___/___

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Responsible Party Form

Responsible Party Information

Relationship to You: _____

Full Name: _____
First *M.I.* *Last*

Same as your address? ☐ Yes ☐ No

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

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Authorizations and Releases

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial _____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Initial _____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial _____

Financial Obligation and Appointment Policy

The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments canceled without any advanced notification required by this office. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or physician.

The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges, when incurred.

Initial _____

Signature _____ Date _____

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Health History Form

Prescription Medications

Prescription medications taken on a regular or ongoing basis:

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

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Vitamins, Minerals, Herbs, or Dietary Supplements

Vitamins, minerals, herbs, or dietary supplements taken on a regular or ongoing basis:

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________

Kuna Chiropractic
& NATUROPATHIC MEDICINE

Comprehensive History

Name _____ **Date** _____

Do you have any of the following conditions?

Yes No Increased Joint Mobility (i.e. Loose joints)

Yes No Significant Bone Loss (i.e. Osteoporosis)

Yes No Benign Bone Tumors (i.e. Non-cancerous)

Yes No Bleeding Disorders

Yes No Take Blood Thinners

Yes No Weakness/Loss of control of your bladder, bowels or muscles

Yes No Inflammatory Joint Disease

Yes No Ankylosing Spondylitis

Yes No Ligament Laxity

Yes No Joint Dislocation

Yes No Recent/Unstable Joints

Yes No Unstable/Missing Dens at C2

Yes No Spinal Cancer

Yes No Spinal/Joint Infection

Yes No Myelopathy/Cauda Equina Syndrome

Yes No Vertebrobasilar Insufficiency Syndrome

Yes No Aterial Aneurysm

Do you consent to treatment using spinal manipulation Yes No

_____ By initialing here, you acknowledge this notice and agree to inform this office if another health care provider tells you that you have one of these conditions. (Please initial on line)

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Do you currently have, or have you had, a problem with any of the following? (If you answer yes, please circle any that apply.)

Yes No **Rapid Change in Weight** (Hypethyroid / Hypothyroid / Other _____)

Yes No **Eyes** (Cataracs / Other_____)

Yes No **Ears, Nose and Throat** (Sleep Apnea / Hearing Loss / Other _____)

Yes No **Heart** (Pacemaker / Defibrillator / High Cholesterol / High Blood Pressure / Stroke / Heart Attack / Angina / Coronary Artery Disease / Congestive Heart Failure / Heart Murmur / Heart Valve Problem / Blood Clots in Legs / Anemia / Blood Transfusion / Bleeding Disorder / Other _____)

Yes No **Lungs** (Asthma / Emphysema / COPD / Other _____)

Yes No **Gastrointestinal** (Crohn's Disease / Ulcerative Colitis / Reflux / GERD / Heartburn / Peptic Ulcers / Liver Cirrhosis / Other Liver Problems / Other _____)

Yes No **Genital/Urinary** _____

Yes No **Muscles/Joints** (Osteoarthritis / Rheumatoid Arthritis / Psoriatic Arthritis / Osteoporosis / Other _____)

Yes No **Skin** (Eczema / Psoriasis / Overgrown Scars / Keloids / Melanoma / Other _____)

Yes No **Nerve** (Epilepsy / Seizures / Fibromyalgia / Other _____)

Yes No **Mental Health** (Depression / Anxiety / Other _____)

Yes No **Diabetes**

Yes No **Leukemia**

Yes No **HIV or AIDS** (Hepatitis A / Hepatitis B / Hepatitis C / Other _____)

Yes No **Hodgkins Disease**

Yes No **Allergies** (Hayfever / Seasonal Allergies / Food Allergies _____)

Yes No **Kidney Problems** (Explain _____)

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Have you had any prior spinal injuries? Yes No If yes, please explain: _____

_____

_____

List ***ANY*** surgeries you have had and the date (if you can't remember the date please list at least the year).

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List ***ANY*** hospitalizations you have had and the date (if you can't remember the date please list at least the year).

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Kuna Chiropractic
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Date of last physical examination: _____

Previous Chiropractic care: Yes No Where and when?_____

_____

Family History (Only include parents, grandparents and siblings)

Heart Disease Yes No If yes, who? _____

Diabetes Yes No If yes, who? _____

Cancer Yes No If yes, who? _____

Spinal Problems Yes No If yes, who? _____

Smoking History (Please mark one):

_____ Current every day smoker

_____ Current some day smoker

_____ Former smoker

_____ Never smoked

Do you consume alcoholic beverages? Yes No If yes, how often _____

How often do you exercise (please circle one):

Daily Weekly Infrequently