NEW PATIENT ADULT HEALTH HISTORY

FUNCTIONAL KIDS THERAPY
every child deserves a champion

- Please fill out on your computer, print it, and bring it to your first appointment.
- Please print out this form, then fill it out using a pen, and bring it to your first appointment.

Note: egardless of the completion method selected above, the diagrams on page three and signatures on pages two, three and five require you to use a pen to complete them. If you email us the form, this can be done in our office.

Patient Contact Information

Patient's Full Name _____ Sex ❑ F ❑ M Date _____/_____/_____

Patient's Social Security # _____ Date of Birth _____/_____/_____ Age _____

E-mail _____

Parent or Guardian's Name (if patient under age 18) _____

Address _____ Apt. (if applicable) _____

City _____ State _____ Zip _____

Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____)_____

Emergency Contact _____ Emergency Contact Phone (_____)_____

Patient's Occupation _____ Employer _____

Patient's Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed If Married, Spouse's Name _____

Number of Children _____ Spouse's Occupation _____ Spouse's Employer _____

Name of Referring Physician, Patient, or Family Member (if applicable) _____

Insurance Coverage Information

Do You Have Health Insurance Coverage? ❑ Yes ❑ No* If yes, please present your health insurance ID card when you arrive at our office for your first visit. We will make a photocopy of it for our files.

If insured, are you the primary name on the policy or is your spouse? ❑ I am the primary name ❑ My spouse is the primary name

If Spouse, Spouse's Name _____ DOB _____/_____/_____

Are You Enrolled in ❑ Medicare ❑ Medicaid ? If you have Medicare supplemental insurance, please present your health insurance ID card when you arrive at the our of fice for your first visit. We will make a photocopy of it for our files.

Are you suffering from an auto accident injury that resulted in a claim? ❑ Yes ❑ No If yes, please bring the auto accident claim information received from your insurance agent. We will make a photocopy of it for our files.

* If you do not have health insurance coverage, Functional Kids Therapy Center LLC offers convenient payment plans that fit most budgets.

Reasons for Seeking Care

Chief Complaint (include location) _____

Rate Intensity (0 = No Pain/Symptoms, 10 = W orst Possible Pain/Symptoms) ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Secondary Complaint, if any (include location) _____

Rate Intensity (0 = No Pain/Symptoms, 10 = W orst Possible Pain/Symptoms) ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Have You Ever Received Chiropractic Care? ❑ Yes ❑ No If Yes, When? _____

Nature of Injury ❑ Automobile ❑ Work ❑ Other _____

Complaint(s) Began When & How? _____

Reasons for Seeking Care (continued)

Description of the Complaint/Pain: ❑ Dull ❑ Aching ❑ Sharp ❑ Shooting ❑ Burning ❑ Throbbing ❑ Deep ❑ Nagging

❑ Other Describe _____

Does This Pain Radiate or Travel (Shoot) to Any Other Areas of Your Body? ❑ Yes ❑ No If Yes, Where? _____

Do You Have Any Numbness or Tingling in Your Body? ❑ Yes ❑ No If Yes, Where? _____

How Frequent Is Complaint Present, How Long Does It Last?_____

Does Anything Aggravate the Pain? _____

Does Anything Make the Pain Better? _____

Medical History

Your Height: _____feet _____inches Your Weight: _____pounds

Previous Care for Your Complaint/Pain (Treatments, Medications, or Surgery You've Sought for Your Complaint) _____

_____

_____

Have You Been Treated for Any Conditions in the Last Year? ❑ Yes ❑ No If Yes, What? _____

_____

Approximate Date of Last Physical Exam_____/_____/_____ Females: Could You Be Pregnant? ❑ Yes ❑ No ❑ Not Sure

Have You Had X-Rays Taken in the Past Three Years? ❑ Yes ❑ No If Yes, Where? _____

What Medications Are You Taking and for What Conditions (Please List Dosage and Amounts, etc.) _____

_____

What Vitamins, Minerals, or Herbs Do You Currently Take? (Please List Dosage and Amounts, and for What Condition, etc.) _____

_____

Average Level of Stress in Your Life

❑ No Stress ❑ Very Little Stress ❑ Some Occasional Stress ❑ Moderate Stress ❑ Significant Stess ❑ High Stress ❑ Severe Stress

FUNctional Kids Financial Policy

You are responsible for knowing your benefits outlined in your specific insurance plan including your co-insurance, co-pay, and deductible amounts if applicable. Please be advised that some insurance providers do not cover chiropractic care. Functional Kids Therapy Center LLC is NOT responsible for these costs that are dictated by your insurance carrier and if coverage is denied you will be responsible for payment of care, including any evaluations.

Should you be delinquent in paying your bill past 3 months and have not made arrangements for a payment schedule, you are legally responsible for the amount outlined by your insurance carrier and will be sent to collections if the account goes unpaid. You are responsible for any finance charges
& fees Functional Kids Therapy Center LLC incurs in collecting therapy service fees from you including legal costs for actions that may be needed to collect on your account(s).

My signature below is confirmation that I have been informed of and agree to the insurance policy of FUNctional Kids Therapy Center LLC.

Parent/Guardian signature: _____ Date:_____

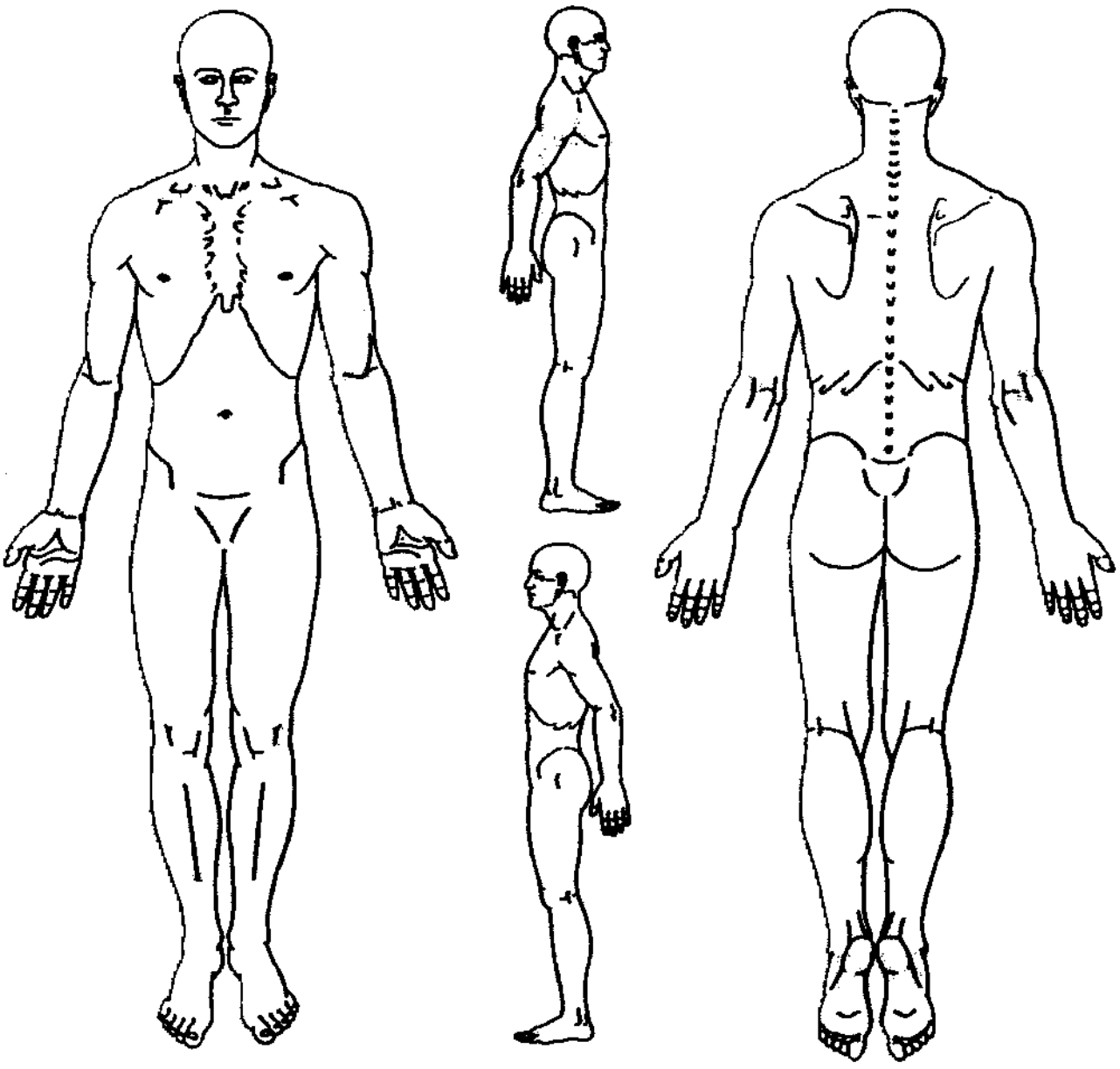
Chiropractic Diagram

• Please print this page and then use a pen to complete the information requested below.

Name _____ Sex ❑ F ❑ M Date _____/_____/_____

Using the Letters Below, Mark the Areas of the Diagram to Indicate Where You Feel the Following Sensations:

A = Aches **B** = Burning **N** = Numbness **P** = Pins & Needles **S** = Stabbing **O** = Other



Indicate the Severity of Your Symptoms by Marking an "X" within the Range Below:

How bad are your symptoms now?

no symptoms/pain most severe symptoms/pain

How bad have they been in the past?

no symptoms/pain most severe symptoms/pain

Your Personal Health Goals

At Functional Kids Therapy Center LLC, we are not only here to help you with your current health issues, but also want to assist you in any way we can by helping you achieve a much higher level of wellness. To help me serve you in the best way possible, please share your personal goals with me. Together, we will look at these goals and make this your healthiest year yet!

Name: _____ Date: _____/_____/_____

My current physical activities include:

❏ Basketball
❏ Baseball/Softball
❏ Bicycling
❏ Bowling
❏ Golf
❏ Tennis
❏ Weight Training
❏ Running
❏ Football
❏ Treadmill/Elliptical
❏ StairMaster
❏ Yoga/Pilates
❏ Dance
❏ Hockey
❏ Martial Arts
❏ Soccer
❏ Swimming/Water Aerobics
❏ Walking
❏ Other: _____

I would feel so much better if I could ...

❏ Decrease my stress
❏ Decrease my anxiety
❏ Sleep better
❏ Have more energy
❏ Handle my food and/or outdoor allergies
❏ Lose weight. I would love to lose _____ pounds!
❏ Eat healthier
❏ Help with sugar cravings
❏ Start a personalized diet, organic diet or gluten-free diet
❏ Lower my blood pressure
❏ Lower my cholesterol
❏ Lower my blood sugar
❏ Increase my flexibility
❏ Strengthen my core muscles
❏ Improve my posture
❏ Improve workstation ergonomics
❏ Quit smoking
❏ Eliminate caffeine
❏ Eliminate alcohol
❏ Decrease fatigue
❏ Have more time with family
❏ Have more time for myself
❏ Learn sport-specific exercises. Sport: _____
❏ Start a new sport/activity: _____

Women Only:

❏ Decrease PMS symptoms
❏ Get pregnant
❏ Balance my hormones
❏ Control menopausal symptoms
❏ Decrease PCOS symptoms
❏ Decrease endometriosis symptoms

Please brainstorm on any other health goals you have that I can assist you with:

_____

_____

Thank you for sharing your most personal goals. I look forward to watching your great progress!

FUNctional Kids Attendance Policy

FUNctional Kids Therapy Center LLC wants to improve your child's quality of life through consistent and high quality care. Cancellations, especially those with less than 24 hour notice including no-call/no-shows limit your child's progress and our ability to care for others. Please call the Battle Creek location at (269) 223-7786 or the Caledonia location at (616) 536-2211 if you need to cancel or reschedule an appointment. We ask for your full cooperation with the following policy:

* If you are unable to keep your scheduled appointment, we request that you notify us immediately so that your appointment can be rescheduled and another patient may take your slot - there is an after hours answering machine for weekends. **You must cancel by noon the previous business day to avoid a $25 cancellation fee (not payable by insurance).**
* Greater than 50% cancellation in a 30 day period will also result in loss of preferred afternoon or early morning time slot(s) until further consistent attendance is established.
* **If you do not show up to a scheduled appointment, a $50 no-show fee will be added to your account and must be paid before resuming therapy (not payable by insurance).** All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payer.
* If you accumulate two no-shows this will result in an automatic discharge and physician notification.
* If you are more than 15 minutes late for your appointment and you do not call the office you will be considered a no-show and will be charged $50 and dismissed from the practice.

We believe that this policy is necessary for the benefit of all patients, so that we can continue to provide high-quality treatment and service to everyone. If you should have any questions regarding this policy, please feel free to discuss them with your therapist.
My signature below is confirmation that I have been informed of and agree to the attendance policy of **FUNctional Kids Therapy Center LLC.**

Patient/Parent/Guardian signature: _____ Date:_____

Notice of Video and Audio Recordings

Functional Kids Therapy Center prides itself on being a safe, inclusive environment for children and families of various backgrounds and needs. To ensure that we are maintaining a safe and inclusive environment, we have decided to add security features to our Battle Creek and Caledonia, Michigan locations, including video and audio recording devices. We have added these devices to main areas of the facilities, such as the waiting rooms and certain exist/ entry points. We value our patients' privacy and we can assure our patients that the recording devices are not located in any private bathrooms or examination rooms. We have posted notices around the facilities to notify our patients of these added security features. As the video and audio recording devices will record protected health information (PHI) and such PHI will be stored electronically (ePHI), please be assured that we have implemented and will utilize these security features in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the HIPAA Policies and Procedures of **Functional Kids Therapy Center, L.L.C.** We maintain appropriate administrative, technical and physical safeguards to ensure the confidentiality and integrity of any PHI and ePHI collected via any video and audio recordings and to protect against any breach or unauthorized use or disclosure of such information. We have also properly trained our workforce with respect to HIPAA rules and regulations as well as the use of these video and audio recording devices. **These devices are secure, closed circuit, password protected accounts that are NOT shared with the public.** We will only disclose video footage or audio recordings as requested by health care providers for treatment purposes, as expressly authorized by patients or as required by law.

By signing below, you acknowledge that **FUNctional Kids Therapy Center LLC** has implemented audio and video recordings on our premises and you authorize us to conduct such recordings.

Signature of Patient/Parent/Guardian:_____ Date: _____

Printed Name of Patient/Parent/Guardian: _____

General Consent For Treatment

GENERAL RELEASE

Regardless of any limitation set forth above, I understand and acknowledge that **Functional Kids Therapy Center** is permitted to make uses and disclosures of my health information for purposes of treatment, payment and health care operations.

I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits that I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

I understand that this information cannot be exchanged without my written consent and hereby give approval as outlines above.

Printed Name of Parent/guardian : _____

Signature of Parent/guardian: _____Date: _____

Consent Form

Photograph/Video Professional Services

I hereby give my consent for **Functional Kids Therapy Center** to use and disclose the professional images/video taken during therapeutic interactions with my child(ren) and the staff at Functional Kids Therapy Center LLC.

With this consent, **Functional Kids Therapy Center** may use these professional images and/or video for the creation of various promotional and marketing materials to promote other professional services to families and community members. This may include but is not limited to dissemination of materials to: other licensed health care professionals, teachers, parents, grandparents, chiropractors, physicians, nurses and any other allied health providers.

With this consent, **Functional Kids Therapy Center** may place this professional video/photo content on their website, Instagram or Facebook page. By signing below, I give Functional Kids permission to disclose what services that my child is receiving in the promotional materials and use their first name in the dialogue to better explain and promote the therapeutic services they are being shown to be participating.

By signing this form, I am consenting to allow **Functional Kids Therapy Center** to use and this imagery and understand that it will be used only for professional services to market and promote the services of the organization

Guardian/Parent Signature:_____Date: _____

AUTHORIZATION FOR ELECTRONIC COMMUNICATION

I consent to the use of electronic communication (which may include a link to an online portal) to contact me as needed. I understand that my service provider may charge me for such communication and also that electronic communication, while very convenient, may not always be very secure.

I authorize to be contacted via text-message at _____
I authorize to be contacted via electronic mail at _____

☐ I prefer to be only contacted via US Mail and telephone number on file.