

Pediatric Patient Contact Information _____

Today's Date _____

Name _____ Name you preferred to be called _____

Date of Birth _____ **Social Security Number** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Cell (____) ____-____ **Home** (____) ____-____ **Work** (____) ____-____ **May we call you at work?** Circle: Yes/No

Employer _____ **Occupation** _____

Email _____

Height ____' ____" **Gender** Male Female

Smoking status Current everyday smoker, Current someday smoker, Former smoker, Never smoked

Frequency 1-5 cigarettes/day 6-10 cigarettes/day 1/2 pack/day 1 pack/day
 1 1/2 pack/day 2 pack/day 2 1/2 pack/day 3+ pack/day

Are you interested in quitting? Yes/No

Race Decline to disclose White American Indian or Alaska Native
 Asian Indian Black, African American Chinese Filipino
 Guamanian Japanese Korean Samoan
 Vietnamese Native Hawaiian, Other Pac. Islander
 Other Asian Other Race

Ethnicity Decline to disclose Not of Hispanic, Latino, or Spanish Origin
 Puerto Rican Another Hispanic, Latino, or Spanish
 Cuban Mexican, Mexican American, or Chicano

Have you visited our website www.kutychiropractic.com? Yes/No

Who may we thank for referring you? _____

Names and Ages of Siblings _____

Parents/Guardians (if patient is a minor) _____

Pediatrician _____ Phone # _____ May we contact your child's Doctor? Yes/No

Insurance Information (if applicable)

Relationship to patient: Self ____ Spouse ____ Parent ____ (please bring a copy of your insurance card)

Name of the Insured _____ Insured's Date of Birth _____

Insurance Company _____

Insurance ID # _____ Group # _____ Phone # _____

Do you have any open liability or work compensation claims? Yes/No _____

Your Child's Health

What health-related concerns prompted today's visit? Onset? Has the child had this before? When?

1. _____

2. _____

What are your goals related to these concerns? _____

List the sports your child is involved in. _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (ie. A bed, changing table, down stairs, etc.). Was this the case with your child? Yes/No

Natal History

Name of Obstetrician/Midwife _____

Were there any complication during pregnancy? _____

Were there any complications during labor and delivery? _____

Forceps? Yes/No Vacuum Extraction? Yes/No C-section, Emergency or Planned? Yes/No

Breastfed? Yes/No If yes, for how long _____

	Current Past		Current Past		Current Past
Ear Infections	<input type="checkbox"/> <input type="checkbox"/>	Seizures	<input type="checkbox"/> <input type="checkbox"/>	Headaches	<input type="checkbox"/> <input type="checkbox"/>
Asthma/Allergies	<input type="checkbox"/> <input type="checkbox"/>	ADHD	<input type="checkbox"/> <input type="checkbox"/>	Growing/Back Pains	<input type="checkbox"/> <input type="checkbox"/>
Colic	<input type="checkbox"/> <input type="checkbox"/>	Car Accident	<input type="checkbox"/> <input type="checkbox"/>	Genetic Disorders	<input type="checkbox"/> <input type="checkbox"/>
Scoliosis	<input type="checkbox"/> <input type="checkbox"/>	Chronic Colds	<input type="checkbox"/> <input type="checkbox"/>	Other	<input type="checkbox"/> <input type="checkbox"/>
Digestive Problems	<input type="checkbox"/> <input type="checkbox"/>	Recurring Fevers	<input type="checkbox"/> <input type="checkbox"/>	_____	_____
Bed Wetting	<input type="checkbox"/> <input type="checkbox"/>	Temper Tantrums	<input type="checkbox"/> <input type="checkbox"/>	_____	_____

Please check the activities that aggravate your child's conditions?

<input type="checkbox"/> Lying on back	<input type="checkbox"/> Getting in/out of car	<input type="checkbox"/> Housework	<input type="checkbox"/> Walking	<input type="checkbox"/> Standing
<input type="checkbox"/> Lying on side	<input type="checkbox"/> Gripping	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Squatting	<input type="checkbox"/> Sneezing
<input type="checkbox"/> Turning in bed	<input type="checkbox"/> Dressing self	<input type="checkbox"/> Pulling	<input type="checkbox"/> Bending forward	<input type="checkbox"/> Coughing
<input type="checkbox"/> Laying on stomach	<input type="checkbox"/> Kneeling	<input type="checkbox"/> Reaching	<input type="checkbox"/> Bending backward	<input type="checkbox"/> Reading
<input type="checkbox"/> Exercise	<input type="checkbox"/> Stretching	<input type="checkbox"/> Computer use	<input type="checkbox"/> Stress	<input type="checkbox"/> _____

Has your child ever been to a Doctor of Chiropractic for treatment? Yes/No When/For? _____

Conditions	Self	Details	Other Family: Parents, Grandparents, Sibling, Child, or Blood-related Aunt/Uncle Details...
Alcohol/Drug Abuse	Yes/No		
Allergies/Sinus	Yes/No		
Arthritis	Yes/No		
Birth Defect	Yes/No		
Cancer/type	Yes/No		
Diabetes	Yes/No		
Depression/Anxiety	Yes/No		
High cholesterol	Yes/No		
Heart Disease	Yes/No		
High Blood Pressure	Yes/No		
Hormone Replacement	Yes/No		
Hysterectomy	Yes/No		
Obesity	Yes/No		
Osteoporosis Osteopenia	Yes/No		
Thyroid Disorder	Yes/No		
Stroke	Yes/No		
Weakness	Yes/No		
Headaches	Yes/No		
Dizziness	Yes/No		
Numbness	Yes/No		
Constipation	Yes/No		
Diarrhea	Yes/No		
Jaw Pain	Yes/No		
Stiff Joints	Yes/No		
Swelling(feet/ankles)	Yes/No		
Other:	Yes/No		

Month or year of your last: Physical Exam? _____ Lab Tests? _____ Normal? Yes/No
Is your child currently being treated by another health care provider? Yes/ No If so, who, how, and for what
reason? _____

Please list any medications your child's taking including * prescription and * over the counter, please list for what
you are taking the medication. Spell clearly.

Please list any 1) allergies your child has to medications 2) his/her reaction to these medications. Spell clearly.

Please list any vitamins, minerals, or supplements your child's taking (please list brands, if known).

Have your child had any surgeries or hospitalizations? Falls, broken bones, dislocations, loss of consciousness?
Car or motorcycle accidents? If so, when and please explain. Go as far back as you can remember.

Health Habits

Rate your child's quality of sleep (0 none – 10 best) _____ How many hours does s/he sleep on average? _____
Rate your child's energy level (0 none – 10 best) _____ What gives him/her energy? _____
Rate your child's stress level (0 none – 10 high) _____ What gives him/her stress? _____
How many ounces does your child drink a day of: Water? _____ Soda? _____ Coffee? ___ Tea? _____
Do your child exercise? Yes/No What type of exercise? How often? _____

How would you describe your child's diet? Healthy _____ So-so _____ Not good _____ Poor _____
Are you interested in nutritional counseling? Yes/No
Current weight? ____ Highest Lifetime Weight ____ Trying to lose weight? Yes/No
To what extent are you open to changes in lifestyle and diet? Eager/ Receptive/ Resistant

Do you have any other concerns about your visit today? _____

*I certify that I have answered truthfully and to the best of my ability. I authorize this office and it's staff to
care for my child as they deem necessary.*

(sign) _____ *(parent/guardian sign)* _____

Printed Name _____ **Date** _____

Discomfort Diagram

Name _____ Date _____

Use the letters below to indicate the type and location of your sensations right now:

A = Achy

D = Pins and Needles

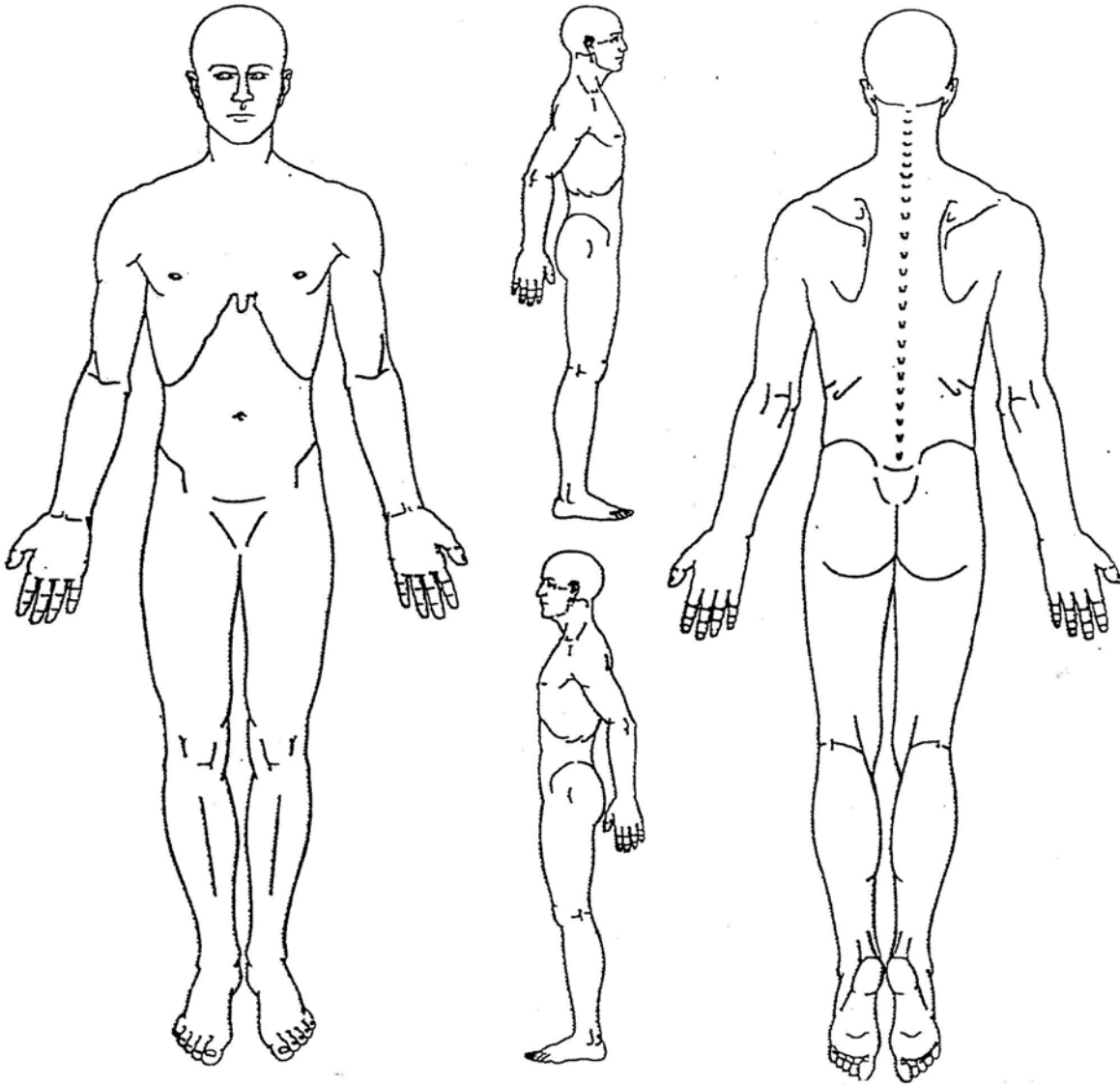
B = Burning

S = Stabbing

N = Numbness

T = Throbbing

O = Other



FOR OFFICE USE: _____ % C/T _____ % L/S Disability
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www.kutychiropractic.com

Patient name: _____

Date: _____

Pain Dysfunction Questionnaire (Spine 2004)

This survey asks for your views about how your pain now affects how you function in everyday activities. This information will help you and your doctor know how you feel and how well you are able to do your daily tasks at this time.

Please answer every question by making an "X" along the line to rate how much your pain problem has affected you from 0 to 10 (from having no problems at all to having the most severe problems you can imagine).

BE SURE TO ANSWER ALL QUESTIONS.

	0	1	2	3	4	5	6	7	8	9	10
F1.	Does your pain interfere with your normal work inside and outside the home?										
	_____ _____ _____ _____ _____										
	Work Normally					Unable to work at all					
F2.	Does your pain interfere with personal care (such as washing, dressing, etc.)?										
	_____ _____ _____ _____ _____										
	Take care of my self completely					Need help with personal care					
F3.	Does your pain interfere with your traveling?										
	_____ _____ _____ _____ _____										
	Travel anywhere I like					Only travel to see doctors					
F4.	Does your pain affect your ability to sit or stand?										
	_____ _____ _____ _____ _____										
	No problems					Cannot sit/stand at all					
F5.	Does your pain affect your ability to lift overhead, grasp objects, or reach for things?										
	_____ _____ _____ _____ _____										
	No problems					Cannot do at all					
F6.	Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?										
	_____ _____ _____ _____ _____										
	No problems					Cannot do at all					
F7.	Does your pain affect your ability to walk or run?										
	_____ _____ _____ _____ _____										
	No problems					Cannot walk/run at all					
P8.	Has your income declined since your pain began?										
	_____ _____ _____ _____ _____										
	No decline					Lost all income					
P9.	Do you have to take pain medication every day to control your pain?										
	_____ _____ _____ _____ _____										
	No medication needed					On pain medication throughout the day					
P10.	Does your pain force you to see doctors much more often than before your pain began?										
	_____ _____ _____ _____ _____										
	Never see doctors					See doctors weekly					
P11.	Does your pain interfere with your ability to see the people who are important to you as much as you would like?										
	_____ _____ _____ _____ _____										
	No problem					Never see them					
F12.	Does your pain interfere with recreational activities and hobbies that important to you?										
	_____ _____ _____ _____ _____										
	No interference					Total interference					
F13.	Do you need the help of your family and friends to complete everyday tasks (both housework and outside work) because of your pain?										
	_____ _____ _____ _____ _____										
	Never need help					Need help all the time					
P14.	Do you now feel more depressed, tense, or anxious than before your pain began?										
	_____ _____ _____ _____ _____										
	No depression/tension					Severe depression/tension					
P15.	Are there emotional problems caused by your pain that interfere with your family, social, or work activities?										
	_____ _____ _____ _____ _____										
	No problems					Severe problems					

FSC _____ PC _____ Total _____

Responsibility for Payment

I understand that I am responsible to verify my insurance eligibility and coverage. If my insurance company denies any portion of my bill, denies visits or medical necessity, applies an unexpected portion to deductible, or does not pay for another reason not here listed, the following applies: I understand that the terms of coverage conveyed to me by this office or by a representative/website from my insurance carrier do not guarantee payment or accuracy. Final payment determination is made by my insurance company upon receipt of the claim and review of documents. I agree to pay any unpaid charges.

_____ Initial to accept

Assignment of Benefits

I hereby authorize and direct my insurance company to pay directly to Kutu Chiropractic such sums as may be due for services rendered. Any funds I receive as payment for services, I agree to promptly direct to Kutu Chiropractic. Any overages may be applied to any non-covered charges.

_____ Initial to accept

Insurance Follow-Up

I understand that it is my responsibility to follow up with my insurance company on incorrectly applied payments, underpayments, and denied charges. I agree to pay the difference between contracted amounts and payments provided to Kutu Chiropractic from my insurance company. As a courtesy Kutu Chiropractic may make an attempt to correct my insurance company’s errors, but I understand that I am responsible to coordinate appeals with the insurance company with whom I have contracted.

_____ Initial to accept

Failure to Pay

If I suspend or terminate my treatment, any fees for services will come immediately due and payable. I understand that I am fully responsible for any costs to collect my bill. Costs may include, but are not limited to collection agency fees, attorney’s fees, and court costs deemed necessary by Kutu Chiropractic to collect my bill. I understand that I will be charged a \$30 late fee per month for any balances due past 30 days. I additionally understand that I will be charged interest of 5% per year on any unpaid balances.

_____ Initial to accept

Designation of Authorized Representative

I designate Dr. Jolene Kutu and Kutu Chiropractic to the full extent permissible under the Employee Retirement Income Security Act of 1974 (ERISA) and as provided in 29 CFR 2560-503-1(b) 4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any health care expenses incurred as a result of the services I receive at Kutu Chiropractic. These rights include acting on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such health care reimbursements.

_____ Initial to accept

Contacting You

I agree to update Kutu Chiropractic with any contact changes. I give permission to Kutu Chiropractic to send me mail, such as welcome, holiday, birthday, and recall cards. I give permission to call me and send emails. Financial statements will be sent to my address on file. I further understand if I fail to update my information, my insurance company may deny my bill and I will be responsible for charges.

_____ Initial to accept

Printed Name

Signature

Date

File Property

All health care files and X-rays taken at this office and ordered to this office are the property of Kutu Chiropractic and will remain on the property of this office. Original x-rays may be checked out for healthcare purposes with authorization so long as they are returned to the office within 10 business days.

_____ Initial to accept

Informed Consent: Permission to Treat

I hereby authorize Kutu Chiropractic, including Dr. Kutu and staff, to treat my conditions as deemed appropriate. I certify that the information given to Kutu Chiropractic is correct and complete to the best of my knowledge. I will not hold Kutu Chiropractic responsible for any pre-existing medically diagnosed conditions or any errors or omissions that I may have made in the completion of any documents.

_____ Initial to accept

Informed Consent: Understanding the Risks

Chiropractic, along with other types of health care, is associated with potential risks. There are also risks of non-treatment by Kutu Chiropractic or other health care providers and delay of other services. Chiropractic is generally considered remarkably safe though I understand that, as in practice of all health care, there are some risks to treatment. Sometimes patients experience post treatment soreness. I will tell the doctor if I experience soreness. Occasionally treatment may aggravate or cause an injury, for example to a joint, ligament, tendon, or other soft tissue. Adjustments, in rare cases, may cause a fracture. Care is taken to minimize these risks. All X-rays are harmful radiation and have associated radiation risks. Ice or heat may cause minor skin burns. Based on the latest research, stroke is not considered a side effect of chiropractic care. Please tell Dr. Kutu all your symptoms, even those you deem unrelated. Any side effects to treatment should be reported to Kutu Chiropractic promptly. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the exam and procedures based the doctors opinions at the time, based on the facts then known, and acting in my best interest. I understand that when appropriate Dr. Kutu or Kutu Chiropractic may refer me to another provider and I agree to follow up on these referrals. I understand that Kutu Chiropractic does not promise any cure for any symptom, condition, or disease as a result of this treatment. I understand that Kutu Chiropractic attempts to provide me with their very best care.

_____ Initial to accept

Keeping my Appointments- Rescheduling and No-Show Fees

I understand that keeping my appointments is important to the success of my prescribed treatment plan. Also, Dr. Kutu and Kutu Chiropractic have reserved a time for my appointment and I am responsible for a fee if I do not make this appointment. I agree to pay **\$20 for rescheduling without 24 hours notice** and further agree to pay **\$35 if I do not show up** for my appointment without prior notice.

_____ Initial to accept

Copy of This Agreement for your Records

I understand that Kutu Chiropractic is offering me a copy of these agreements including HIPAA Notice of Privacy Practices and I have let them know if I would like a copy for my records. Further, I understand that this information is available to me by request at a later date.

_____ Initial to accept

I read and understood this entire document. I, _____, accept and consent to all of the above.
Printed name

_____	_____	_____	_____
Signature of patient	Date	Signature of staff	Date
_____	_____	_____	_____
Signature of guardian if applicable	Date	Printed name of guardian	Date

**Kuty Chiropractic
Consent for Treatment of a Minor**

Patient Name: _____ Date of Birth: _____

Parent(s) or Legal Guardian(s): _____

I hereby authorize Dr. Jolene Kuty, Kuty Chiropractic LLC, and whomever she may designate as assistants to administer examinations and treatment as deemed necessary to the minor of which I am parent or legal guardian.

Signature of Parent or Legal Guardian _____

Date Signed _____

Additional Remarks:

