KiNESiS Chiropractic & Physical Medicine
3662 Katella Ave., Suite #205
Los Alamitos, CA 90720

Patient Intake Form
(Please Print)

Full Name ____ Social Security #____________________ Sex: [] Male [] Female
Address ____ City ________________________ State_____ Zip___________
Date of Birth__________________ email____ Marital Status: _________
Home Phone ________________________ Cell Phone ___________________________ Work _______________________
Occupation/Employer _____________________________________ Business City/St/Zip_______________________________
How did you hear about us? __Internet __Family/Friend __Referral __Other____
Whom can we thank for referring you to us? ____

If insured, an insurance card will be required on the first visit so we may verify your benefit eligibility on your behalf. The following information is required by most insurance companies:

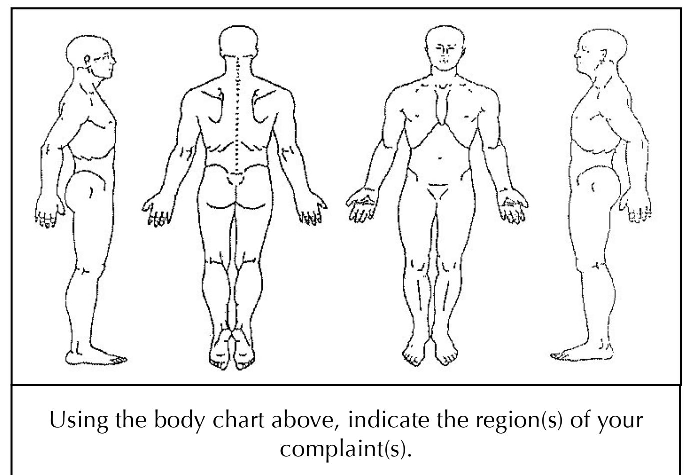
Name of Insured ____ Relationship to Patient_____________________________
Date of Birth______________ SSN______________________ Insurance Comp_____________________________________
Policy # ______________________________Group #_____________________________
Is this condition due to an accident? [] Yes [] No Type of Accident: [] Work Injury [] Auto Accident [] Sport [] Other

Emergency Contact Name____________________________________ Relationship to Patient__________________________
Phone Number: Work ____________________________________Home_______________________________________

SUBJECTIVE (please fill out completely)

Reason For Today's Visit ____
My Complaint is best described as: __Pain __Numbness __Swelling __Muscle Spasms __Headache __Tightness __Stiffness
WHEN did you first notice your condition? ______________________________________ OR __Not Sure
The CAUSE of the injury(s): __Trauma __Repetitive Actions __Auto Accident __Post-Surgical Complication __Unspecified Reason __Other____
The QUALITY of my main complaint is BEST described as: __Sharp __Dull __Aching __Throbbing __Crushing __Stabbing __Burning __Shooting __Other_______________________________
My headaches, if any, are best described as: __Migraine __Tension __Hormonal __Sinus __Organic
I experience my complaint: __Constantly __Frequently __Intermittently __Occasionally

Please rate the Severity of each complaint you present with today (Please circle)…(0= No Pain,10=Extreme Pain)
1. _________________________________ 0 1 2 3 4 5 6 7 8 9 10
2. _________________________________ 0 1 2 3 4 5 6 7 8 9 10
3. _________________________________ 0 1 2 3 4 5 6 7 8 9 10
4. _________________________________ 0 1 2 3 4 5 6 7 8 9 10



Using the body chart above, indicate the region(s) of your complaint(s).

I experience my pain: __ Worse in the morning __Worse at midday __Worse at night __Pain is consistent all day
Describe what makes your condition feel better (Heat / Ice / Rest / Sleep / Positions) _______________________________________
Have you had this condition before? [] Yes [] No
If yes, When? _________________________

Describe any prior treatment for this condition____
What is/are your health goal(s)? ____
List ALL previous Surgeries: ____
List ALL Drugs/Medications you currently use (prescription and over-the-counter) ___________________________________
____
List Any Vitamins/Supplements you are currently using ____
____

Supplemental Health History

Please mark the appropriate box for any current or previous health conditions

Musculoskeletal

❑ Auto Accidents
___0-1 years ago
___1-5 years ago
___More than 5 years ago
❑ Fractured Bones
❑ Pain/Stiff Neck R / L
❑ Back Pain/Stiffness R / L
❑ Numbness/Tingling in Arms/Hands/Fingers R / L
❑ Numbness/Tingling in Legs/Feet/Toes R / L
❑ Swollen/Painful Joints
❑ Difficulty with Prolonged Standing, Walking, Driving
❑ Difficulty Performing Daily Activities
❑ Back Curvature
❑ Arthritis
❑ Jaw Pain/TMJ R / L
❑ Foot Trouble R / L
❑ Hip Pain R / L

Neurological

❑ Convulsions/Epilepsy
❑ Learning Disability
❑ Loss of Balance
❑ Dizziness
❑ Ringing in Ears R / L
❑ Trouble Concentrating
❑ Irritable
❑ Fainting
❑ Hearing Lost R /L
❑ Tremors
❑ Double Vision R / L
❑ Trouble Sleeping
❑ Blurred Vision R / L
❑ Headache
❑ Pain with cough/sneeze
❑ Mood Changes
❑ Depressed
❑ Eating Disorders

Digestive

❑ Diarrhea/Constipation
❑ Heartburn
❑ Colon Trouble
❑ Gall Bladder Trouble
❑ Diabetes
❑ Ulcers
❑ Hemorrhoids

Immune

❑ Frequent Colds/flu
❑ Difficulty Breathing
❑ Asthma
❑ Ear Infection
❑ Allergies
❑ Cancer
❑ AIDS/HIV

Other Systems

❑ Kidney Trouble
❑ Chest Pain
❑ Lung Problems
❑ Heart Problems
❑ Liver Trouble
❑ High/Low Blood Pressure
❑ Stroke
❑ Anemia
❑ Bed Wetting
❑ Prostate Problems
❑ Skin Problems
❑ Thyroid Problems
❑ Varicose Veins
❑ Menopausal Problems
❑ Menstrual Problems/PMS
❑ Pregnant
❑ Endometriosis
❑ Ovarian/Uterine Cysts

EXERCISE

❑ None — Types of Exercise
❑ Moderate ________________________
❑ Daily ________________________
❑ Heavy ________________________

WORK ACTIVITY

❑ Sitting
❑ Standing
❑ Light Labor
❑ Heavy Labor

HABITS

❑ Smoking — Packs/Day ___________
❑ Alcohol — Drinks/week __________
❑ Coffee/Caffeine — Cups/Day ___________
❑ High Stress Level — Reason _____________

ACTIVITIES OF DAILY LIVING

ACTIVITY	No Pain	Mild Pain	Tolerable Pain	Moderate Pain	Severe Pain	Disabling Pain
Walking	❑	❑	❑	❑	❑	❑
Sitting	❑	❑	❑	❑	❑	❑
Bending	❑	❑	❑	❑	❑	❑
Standing	❑	❑	❑	❑	❑	❑
Sleeping	❑	❑	❑	❑	❑	❑
Lifting	❑	❑	❑	❑	❑	❑
Running	❑	❑	❑	❑	❑	❑
Climbing Stairs	❑	❑	❑	❑	❑	❑
Carrying	❑	❑	❑	❑	❑	❑
Driving	❑	❑	❑	❑	❑	❑
Dressing	❑	❑	❑	❑	❑	❑
Reading	❑	❑	❑	❑	❑	❑
Household Chores	❑	❑	❑	❑	❑	❑
Gardening	❑	❑	❑	❑	❑	❑
Sports	❑	❑	❑	❑	❑	❑
Sitting to Standing	❑	❑	❑	❑	❑	❑
Rolling Over	❑	❑	❑	❑	❑	❑
Computer Work	❑	❑	❑	❑	❑	❑

The above information is true and accurate to the best of my knowledge.

Signature: ____ Date: ____________________

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Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use you health information within our practice for quality control or other operational purposes.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to Mallory M. Feinberg, D.C. or Jack C. Hewitt, D.C. dba: Kinesis Chiropractic & Physical Medicine of all benefits that may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. However, I clearly understand that all services rendered to me are charged to me and I am responsible for payment unless other arrangements are made.

Furthermore, I hereby IRREVOCABLY ASSIGN to Mallory M. Feinberg, D.C. or Jack C. Hewitt, D.C. dba: Kinesis Chiropractic & Physical Medicine the rights and benefits under any policy of insurance, indemnity agreement, and/or charges provided by Mallory M. Feinberg, D.C. or Jack C. Hewitt, D.C.

Authorization to Release Medical Record Information:

Mallory M. Feinberg, D.C. and/or Jack C. Hewitt, D.C. is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services rendered by Mallory M. Feinberg, D.C. or Jack C. Hewitt, D.C. dba: Kinesis Chiropractic & Physical Medicine. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said Mallory M. Feinberg, D.C. or Jack C. Hewitt, D.C. dba: Kinesis Chiropractic & Physical Medicine.

I have read your consent policy and agree to its terms. I am also acknowledging that I may receive a copy of this notice at anytime and that the original will remain in my medical record.

______________________________	______________________________
Printed Name	Authorized Provider Representative
______________________________	______________________________
Signature	Date

KiNESiS

Chiropractic & Physical Medicine

Thank you for choosing Kinesis Chiropractic and Physical Medicine. We are committed to the success of your treatment. We hope you understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to, and sign prior to any treatment. This financial policy applies to all services rendered by all providers in our office.

It is our policy that the patient, rather than the insurance company, is responsible for complete payment of our charges. All patients with insurance coverage are required to pay for non-covered services, any deductible amount not previously met and any co-pay/co-insurance due at the time services are rendered. For patients with dual insurance coverage, we will bill both the primary and secondary insurance if you have provided us with the necessary information.

If you are insured with a plan which we are contracted with, you will need to pay for any non-covered services, any outstanding deductible and co-pay/co-insurance at the time of you visit. Failure to pay outstanding balance within 90 days of notification of the amount due will result in collection proceedings unless prior arrangements are made.

All patients that do not have insurance, payment is due at the time services are rendered. For your convenience we accept all major credit cards. If you should have any further questions, we will be glad to assist you.

24 Hour Cancellation/Rescheduled Policies of Appointment

All cancelled/rescheduled appointments without a 24 Hour notice will be charged the following:

- Chiropractic Appointments $15.00
- Massage Therapy appointments will be charged the full rate

I have reviewed the attached personal information and confirm that all the information is accurate.

"I have read, understand and agree to the provisions of this policy."

____________________	____________________	__________
Patient Name	Signature Patient/Guardian	Date