WELCOME

Date_____/_____/_____

Name_____ I preferred to be called_____

Address_____

_____

_____

Home Phone__(____)_____

Cell Phone_(____)_____

Work Phone (_____)_____

Circle appropriate choice. I prefer to be contacted on my:

HOME PHONE WORK PHONE CELL PHONE

Email_____

Employer_____ Occupation_____

Date of Birth_____/_____/_____

Circle Appropriate choice:
MINOR SINGLE MARRIED DIVORCED SEPERATED WIDOWED

Spouse or Parents Name_____

Emergency Contact_____Phone#_____Relationship_____

Allow my emergency contact access to my PHI and billing information if necessary_ _yes____no_____

Primary Medical Doctor_____ Phone#_____

Clinic_____

When doctors work together it benefits you. Do we have permission to contact your primary healthcare provider regarding your care?__yes____no____

Whom may we thank for referring you? _____

Patient name_____. Date_____

1What are your major complaints_? A)_____

B)_____

C)_____

2) What do you think has **caused** your problem? _____
3) How **long** have you had this condition? _____
4) Have you had this or **similar conditions before**? Yes or No (Circle One). Please Describe: _____
_____
5) Did this condition start: Gradually or Suddenly (Circle One).
6) Is this condition getting: Better or Worse or Stays the Same (Circle One).
7) Is this condition: Constant or Comes and goes (Circle One).
8) If you have **pain**, is it: Sharp or Dull or Burning or Aching or Throbbing or Numb/Tingling
9) Does this condition affect your: Arms or Legs or Other _____
10) Is this condition **worse** at: Morning or Evening or No Difference (Circle One).
11) What activities or positions **aggravate** this condition?_____
12) What activities or positions **relieve** this condition? _____
13) Is this condition interfering with your: Work or Sleep or Daily Routine or Other _____
14) Is there anything you have tried yourself to **relieve** this condition, such as: (Circle all that apply)
Heat or Ice or Rest or Exercise or Pills or Other _____
15) Have you seen any **other doctors** for this condition? Yes or No (Circle One).
If so, whom? _____
16) If you saw another doctor, did he **treat** you or **prescribe** anything for you? Yes or No (Circle One).
If so, please describe _____
17) Have you lost any days from work with this condition? Yes or No (Circle One).
18) Have others in your **family** had this or similar conditions? Yes or No (Circle One).
If so, please describe _____
_____
19) Have you had any **previous accidents or injuries** within:
One year or Five years or Over 5 years or Never (Circle One).
If so, please describe _____
20) Do you take **ANY medications**? Yes or No (Circle One). Please Describe: _____
_____
21) List all your **surgeries** and years you had them: _____
_____
22) Have you had any **previous chiropractic care**? Yes or No (Circle One).
If so, from **whom** and **when** _____
For what kind of problem? _____
23) Have you ever had any mental or emotional disorders? Yes or No (Circle One).

Patient Name:_____

Lifestyle / Self Care Issues

Have you ever smoked cigarettes? ☐ Yes ☐ No
If yes,_____packs per day. Smoked for____ years
Are you still smoking? ☐ Yes ☐ No
Do you drink caffeinated beverages? ☐ Yes ☐ No
If yes, _____cups, cans, etc/per day
Do you drink alcohol? ☐ Yes ☐ No
If yes, _____ number of drinks /week_____
Previous drug/alcohol problems? ☐ Yes ☐ No
Do you manage stress well? ☐ Yes ☐ No ☐ Need Help
Do you exercise regularly? ☐ Yes ☐ No
Type/Frequency _____
Do you sleep soundly? ☐ Yes ☐ No
Are you satisfied with your social life? ☐ Yes ☐ No
Is your diet healthy enough? ☐ Yes ☐ No
☐ Not Sure ☐ Need Help

Diet Habits and Typical Daily Intake

Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
Fluids: Cups of water:_____ Other Fluids:_____

Current Medications	Dosage	Times/day

Current Vitamins/Herbs	Dosage	Times/day

Review of Systems: (circle current problems, check past problems)

Constitutional
__ decreased sleep
__irregular sleep
__excessive sleep
__ poor appetite
__fevers
__chills
__food cravings
__weight loss
__weight gain
__fatigue

Immune System
__too many infections
__allergies to food or environment
__other concerns

Mood, Thoughts, And Emotions
__manic episodes
__energy problems
__spiritual needs
__anger problems
__depression
__lonliness
__apathy
__don't care anymore
__panic/fear attacks
__anxiety
__hopelessness
__isolated from family Friends, & coworkers

Skin & Hair
__mole changes
__dry skin/eczema
__rashes/ hives
__hair loss

Hormones/Metabolism
__thyroid trouble
__fluid retention
__weight and diet trouble

Ears, Nose, Mouth, Throat
__ringing ears
__nose bleeds
__postnasal drip
__sinus problems
__trouble with taste/smell
__ poor hearing
__earaches
__bad breath
__headaches
__facial pain
__jaw clicks
__teeth problems
__grinding teeth
__trouble chewing
__sore throats

Eyes
__eye pain
__blurred vision
__Poor vision__day__night
__wear corrective lenses
__near or far sighted
__other:_____

Breathing and Lungs
__shortness of breath
__wheezing or asthma
__repeated colds or flu
__cough, dry or irritating
__cough up mucus or blood

Heart & Circulation
__chest pain
__lightheadedness
__palpations
__cold hands/feet
__fainting
__swelling feet
__blood clots
__varicose veins

Digestion and Intestines
__ Indigestion
__ belching
__difficult swallowing
__heartburn
__nausea
__liver trouble
__vomiting
__ blood in stools
__diarrhea
__foods that upset your stomach
_____
__cramping bowels
__gassy gut
__constipation
__abdominal pain
__rectal pain or itching
__hemmroids

Nerves, Movement, Brain
__seizures
__nerve pains
__poor balance
__ poor coordination
__tremors or shaking
__numbness
__dizziness
__poor memory
__trouble sleeping

Muscles, Bones, Joints
__neck pain
__back pain
__muscle pain
__muscle weakness
__muscle cramps
__joint swelling
__painful joints R__L__
__shoulder __elbow
__hip __knee __ankle
__foot __toe __hand
__wrist __fingers

Urine, Kidneys, Bladder
__ decreased urine flow
__ blood/pus in urine
__ painful urination
__ wake up to urinate
__kidney stones
__loss control of urine
__ sudden urges to pee
__frequent urination

Women's Reproductive
__ age period started
__number of pregnancies
__pregnancies lost
__past fertility problems
__number of live births
__children currently living
__age period stopped/ menopause

Sexual Organs
__sores on genitals
__lumps or swelling
__erection problems
__poor sexual response
__pain with sex
__infertility
__repeated infections
Women:
__pelvic pain
__vaginal discharge
__painful periods
__PMS symptoms
__hot flashes
__itching or soreness
__breast lumps or pain
__breasts leak fluid

Blood System
__lymph gland swelling
__anemia
__easy bruising

INFORMED CONSENT

Medical doctors, Chiropractic doctors, Osteopathic doctors, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I do hereby give my consent to the treatment that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, physical therapy, diagnostic x-rays, acupuncture.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and /or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment. I do not expect the doctor to be able to anticipate all risks and complication, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time b based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses that are preexisting given by anther heath care practitioner or are not related to the spinal structural conditions treated at this clinic. Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

I ,_____ have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below, I agree to the care, I intend this consent form to cover the entire course for treatment for my present condition and for any future condition for which I seek treatment.

Signature_____ date_____

CONSENT TO TREATMENT OF A MINOR

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

I authorize this minor child, _____ to receive treatment at this office when I am not present. Yes. No

Relationship to child _____

Parent or Guardian signature_____ date_____

FINANCIAL RESPONSIBILITY AGREEMENT

- I understand that as a patient of Dr. Jasmine Kim, it is my responsibility to know my insurance plan and what benefits are covered, to know if and when a referral is necessary and to have verified that the providerI am seeking care from is in network with my benefits. Any balance remaining after insurance has paid is my responsibility in full.
- I also understand and accept that I will be responsible for charges in the following situations in accordance with state provider billing guidelines.

1. All payments are due at the time of service, including copays, co-insurance, deductibles, and non-covered services.
2. Any covered and non-covered services are the responsibility of the patient at the rate determined by the insurance company's explanation of benefits. Final approval of coverage is based on the explanation of benefits after the claim has been filed.
3. If unable to make your appointment, please notify our office at least 24 hours' notice out of respect and courtesy to other patients. After two missed/cancelled visits without 24-hour notice, you will be charged $50.00 for each visit that is missed.
4. It is our policy to collect $25 for returned checks to cover any fees that apply from the transaction.
5. If full payment is not received, the card on file will automatically be charged for the remaining balance that the end of each business day unless other arrangement are made in advance. If you are unable to pay in full, please ask about payment plan options.
6.

Designation of Authorized Representative

- I do hereby designate Dr. Jasmine Kim Inc to the full extent permissible under the Employee Retirement income Security Act of 1974("ERISA") and as provided in 29CR 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 medical or their health care expenses incurred as a result of the service I receive from Dr. Kim. These rights include the right to act 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 medical or other health care service benefits, health care benefit plan reimbursement and to pursue any or the applicable remedies.
- I do hereby authorize Dr. Jasmine Kim to act on my behalf to pursue claims and exercise all rights in order to collect payments with respect to any medical or other health care expenses incurred as a result of the service I receive from Dr. Jasmine Kim.

Payment method. Self-Pay. Health Insurance. Auto insurance. Worker's Compensation. Other

If you are here for treatment due to an Auto injury or WC injury, please ask front desk for additional paperwork.

Insurance Carrier_____ Policy number_____ Group number_____

Insured's Name_____ Insured's date of birth_____ relationship to insured_____

Billing address, if different from patient.

Name_____ Address_____

City_____ State_____ Zip code_____-

By signing this form, I agree to this financial agreement and acknowledge that I have read and understand that I will assume full responsibility for the total billed charges related to any and all non- covered services.

Signature of patient_____ date_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health and Portability and aAcountability Act of 1996("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential.

In the course of your care a s a patient of at the office of Dr. Jasmine Kim, we may need to use or disclose personal and health related information about you in the following ways:

- Your personal health information including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer if they are responsible for payment of your services.
- Your name, address, email, phone number, and your health care records may be used to contact you regarding appointment reminders or other appointment related issues, to provide information about alternatives to your present care or other health related information that may be of interest to you. Periodically, thank you letters, referral cards, newsletters, birthday cards, postcards, paper clippings or email messages may be sent.

If you are not at home to receive an appointment reminder, a message me be left on your answering machine or with another member of your family of the household. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

- Under federal law, we are also permitted or required to use or disclose your health insurance without your consent or authorization in the following circumstances.
- We are providing health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you but in our professional judgement, we believe that you intend for us to provide care.
- If we are order by the courts or another appropriate agency

Any use of disclosure of your protected health information other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive care from us. We may also mail information to you regarding your care, insurance forms, or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like information in a different form, please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and to protect the health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to your privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your information in our files.

In addition, we may disclose your Personal Health Information to a family or close friend they accompany you while receiving health care services or if we determine that it is in your best interest so we can provide you with the best health care possible. We may also disclose your PHI to a family member or someone else who helps pay for your health care treatment.

- You have the right to inspect and copy PHI that me be used to make decisions about your care, including medical and billing records. You must submit your request in writing. We will respond within 30 days.
- Email risk and responsibility. As the Internet is not secure or private, unauthorized people may be able to intercept, read and possibly modify email you send to or receive from us.it is solely your responsibility to protect your own email account, password and computer against access by unauthorized people. Since emails can easily be copied, printed, and forwarded, you should be careful regarding to whom you send information. We reserve the right to save your email and include your email for information contained in your medical record. You should immediately inform us of a change in your email address. If you wish to withdraw the consent to communicate by email, you must send it in writing stating such.
- You understand that if you opt for appointment reminders via text that you will receive text reminders. You also understand that if you respond to this to change/reschedule/confirm via text, it utilized email to relay communication.
- You understand that it is your choice to communicate via social media platforms and that if you choose to communicate via social media, you have consented to utilizing this platform for future communication.

If you have a complaint regarding our privacy notice and /or privacy practices or would like further information about our privacy policies and practices, please contact Dr. Jasmine Kim.

Dr. jasmine Kim Inc will use reasonable means to protect the privacy of the patient's health information. However, because of the risks outlined above, we cannot guarantee that email will be confidential. Additionally, Dr. jasmine Kim Inc will not be liable in the event that you or anyone else inappropriately uses or accesses you email. We sill not be liable for improper disclosure of your health information that is not caused my intentional misconduct by agents of Dr. Jasmine Kim, Inc.

By signing below, I acknowledge that I have read and fully understand this consent form. I understand that this consent is valid until such time as I revoke the consent as outline above, except to the extent that a person who is to make communication has already acted in reliance upon this authorization.

_____ . _____ . _____

Name please print(minors name) signature Date

Neck Disability Index Questionnaire (NDI)

Name: **Date:**

*This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but* **Please just circle the one choice which closely describes your problem right now.**

SECTION 1--Pain Intensity
A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading
A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache
A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

DISABILITY INDEX SCORE: _____%

SECTION 6 -- Concentration
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving
A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping
A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation
A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities all all.

Source: Vernon H, Mior S. The Neck Disability Index: a study of reliability and validity. J Manipulative Physiol Ther 1991;14(7):409-15.

Revised Oswestry Disability Index (ODI)

Name: **Date:**

*This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but* **Please just circle the one choice which closely describes your problem right now.**

SECTION 1 – Pain Intensity
A. The pain comes and goes and is very mild
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain, and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing or dressing without help.
F. Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 – Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights off of the floor.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
F. I can only lift very light weights at the most.

SECTION 4 – Walking
A. I have no pain walking.
B. I have some pain walking, but I can still walk my required normal distances.
C. Pain prevents me from walking long distances.
D. Pain prevents me from walking intermediate distances.
E. Pain prevents me from walking even short distances.
F. Pain prevents me from walking at all.

SECTION 5 – Sitting
A. Sitting does not cause me any pain.
B. I can sit as long as I need provided I have my choice of sitting surfaces.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than 1/2 hour.
E. Pain prevents me from sitting more than 10 minutes
F. Pain prevents me from sitting at all.

SECTION 6 – Standing
A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for more than one hour without increasing pain.
D. I cannot stand for more than ½ hour without increasing pain.
E. I cannot stand for more than 10 minutes without increasing pain.
F. I avoid standing because it increases my pain right away.

SECTION 7 – Sleeping
A. I have no pain in bed.
B. I have pain in bed but it does not prevent me from sleeping well.
C. Because of pain I only sleep ¾ of normal time.
D. Because of pain I only sleep ½ of normal time.
E. Because of pain I only sleep ¼ of normal time.
F. Pain prevents me from sleeping at all.

SECTION 8 –Social Life
A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of pain.
C. Pain prevents me from participating in more energetic activities, eg sports, dancing.
D. Pain prevents me from going out very often.
E. Pain has restricted my social life to home.
F. I hardly have any social life because of pain.

SECTION 9 – Traveling
A. I get no pain while traveling.
B. I get some pain while traveling but none of my usual forms of travel make it any worse.
C. I get some pain while traveling, but it does not cause me to seek alternative forms of travel.
D. I get extra pain from travel that causes me to seek alternative forms of travel.
E. Pain restricts me from all forms of travel,
F. Pain restricts me from all forms of travel, except that done lying down.

SECTION 10 – Employment / Homemaking
A. My normal job/homemaking activities do not cause me pain.
B. My normal job/homemaking activities cause me extra pain, but I can still perform all that is required of me.
C. I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities eg, lifting, vacuuming.
D. Pain prevents me from doing anything but light duties.
E. Pain prevents me from doing even light duties.
F. Pain prevents me from performing any job or homemaking chore.

DISABILITY INDEX SCORE: _____ %

Source: Fairbank JC, Couper J, Davies JB, O'Brien JP. The Oswestry low back pain disability questionnaire. Physiotherapy 1980;66(8):271-3.

Name _____ **Date** _____

Mark all the areas of the body where you feel the described sensations. Use the appropriate symbol. Include ALL AFFECTED AREAS.

A = ACHE **B = BURNING** **N = NUMBNESS**
P = PINS & NEEDLES **S = STABBING** **O = OTHER**