Dr. Jodi Kennedy, DC

WELCOME

Integrity Chiropractic
11 Miller Rd
Mahopac,NY 10541

PATIENT INFORMATION

Date _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

Birthdate _____ Age _____ Sex ☐ M ☐ F

☐Married ☐Widowed ☐Divorced ☐Single ☐Minor

E-mail _____

Would You Like to Receive our Newsletter? ☐ Yes ☐ No

INSURANCE

Subscribers Name _____

Birthday _____ Relationship to Patient _____

Insurance Co. _____ Policy# _____

I have out network benefits ☐ Yes ☐ No Deductible _____

Is patient covered by additional insurance? ☐Yes ☐ No

Subscriber's Name _____

Birthday _____ Relationship to Patient _____

Insurance Co. _____ Policy# _____

Whom may we thank for referring you? _____

PRIVACY PRACTICE & RELEASE

ACKNOWLEDGEMENT PRIVACY PRACTICES

You may refuse to sign this Acknowledgment

I acknowledge that I have read and understand the Notice of Privacy Practices. I agree to its terms. (A copy of Notice Privacy Practices is available for review on our website & in hard copy on request)

RELEASE OF RECORDS

I authorize the release of all requested medical & accident information related to my condition verbally & in writing to Dr. Jodi Kennedy(D.B.A Integrity Chiropractic). I understand that my health information will not be released to any person other than my doctor & her staff involved in my care & the handling of my insurance claim. I understand I'm financially responsible for all charges whether or not paid by insurance.

Integrity Chiropractic may use my signature on all insurance submissions & disclose my health information to above-named Insurance Company(ies) & agents for the purpose of payment. I understand that the disclosed information may include information about mental illness, alcohol or substance abuse or AIDS/HIV. I may revoke this authorization at any time by mailing written notification to Integrity Chiropractic

Signature X _____

Print Name _____

Relation to Patient _____ **Date** _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time & way to reach you _____

EMERGENCY CONTACT

Name _____

Relationship _____

Cell Phone (_____) _____

Work Phone (_____) _____

FINANCIAL POLICY

- I agree to pay a **$25.00 cancellation** fee for all appointments canceled with less than **48 hours notice** ☐Yes ☐No
- I agree to pay a **16% late fee** for all account balances that are 31+ days past due. ☐Yes ☐No
- I understand that Dr. Kennedy is an out-network provider & agree to provide full payment at time of service. ☐Yes ☐No
- I understand that it's my responsibility to call & verify my out-network benefits & annual deductible. ☐Yes ☐No

Signature X _____ **Date** _____

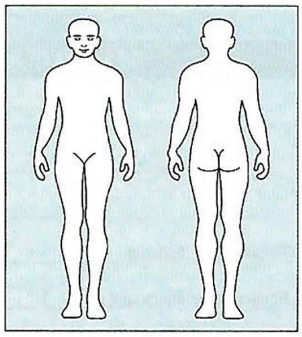
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐Yes ☐No ☐Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 1 o(severe pain)

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Lifting

Dr. Jodi Kennedy, DC

HEALTH HISTORY

Integrity Chiropractic
11 Miller Rd, Mahopac NY 10541

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Chiropractic ☐ Physical Therapy ☐ Acupuncture ☐ Massage ☐ Nutritionist ☐ Ice/Heat ☐ Other

Is condition due to an accident? ☐Yes ☐No Date _____ **Type of accident** ☐ Auto ☐ Work ☐ Home ☐ Other

Last date of- Physical Exam: _____ _____ _____

_____ Spinal X-ray: _____ Blood Test: _____

MRI: _____ CT-Scan or Bone Scan: _____ Other: _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Lymes disease	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Concussion	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Other	☐ Yes ☐ No
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None **Describe:**
☐ Moderate _____
☐ Daily _____
☐ Heavy _____

WORK ACTIVITY

☐ Sitting **Describe:**
☐ Standing _____
☐ Light Labor _____
☐ Heavy Labor _____

HABITS

☐ Smoking- Packs/Day___
☐ Alcohol- Drinks/Week___
☐ Caffeine- Cups/Day___
☐ High Stress Level

SLEEP & DIET

Sleep Position:
☐ Back ☐ Side ☐ Stomach
Hours Sleep at Night: _____
Diet: ☐ Good ☐ Fair ☐ Poor

Are you pregnant? ☐ Yes ☐ No Due Date: _____ **Date of last menstrual cycle** _____

Injuries you've had:

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

SOCIAL

Number & Name Kids: _____
_____
Spouse/Partner's Name: _____
Occupation: _____
☐ Full-Time ☐ Part-Time

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

Signature: X _____ **Print Name** _____ **Date** _____

☐ Adult ☐ Parent ☐ Guardian