Joshua A. Kilpatrick DC
Chiropractic
Acupuncture
Nutrition

SPORTS & FAMILY CHIROPRACTIC & ACUPUNCTURE

Sports & Family Chiropractic & Acupuncture,LLC
10510 old Olive Street Rd.
Creve Coeur, MO 63141
drjoshkilpatrick.com
314-991-2295

Confidential Registration Form

Please Print

Today's Date____/____/____

PATIENT INFORMATION

Patient' s Last Name **First** **Middle Int.** **Marital Status:**

M S W D

Social Security #	Home Phone #	Cell Phone #	Birth Date	Age	Sex
	( )	( )	/ /		☐ M F

Street Address City State Zip Code	Email Address

Occupation	Employer	Work Phone #
		( ) ext.

The best place to contact me is (circle one): Home Work Cell Email

Whom may we thank for referring you?	Family Doctor	Family Doctor address or City	Family Doctor Phone #
☐Insurance Plan ☐Hospital ☐Location ☐Patient_____ ☐Dr. _____ ☐Internet Search ☐Family/ Friend _____ ☐Other _____			( )

Name of local Friend or Relative	Relationship to Patient	Home Phone #	Cell Phone #
		( )	( )

PATIENT CONDITION

Reason for your visit today?

When did your symptoms first appear? **What do you believe caused your symptoms?**

Are the injuries/conditions you are seeking treatment for related to and open auto accident, personal injury of workers compensation claim?
☐YES * if yes please inform the front desk before treatment is initiated.
☐NO

Imaging preformed for your symptoms
☐X-rays (Date)_____
☐MRI (Date)_____
☐Other (Date)

Habits:
☐Smoking_____pack(s) a day for _____year(s)
☐Alcohol _____drinks per week
☐Caffeine Drinks _____cups per day
☐High Stress? Reason:

What is your exercise level?
☐None
☐Moderate
☐Daily
☐Heavy
☐Type: _____

Please List any *Medications or Supplements* that you are currently taking:

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PATIENT HISTORY

Previous Auto Accidents or Trauma?

_____

Description Date

Falls: _____

Head Injuries: _____

Fractures: _____

Broken Bones: _____-

Dislocations: _____

Recent or Major
Surgeries:_____

Have you been diagnosed or been told you have any of the following? (please check and/or circle all that apply)

- ☐Cancer
- ☐Heart condition/Cardiovascular Condition
- ☐Skin / Breast Condition
- ☐Osteoporosis/Bone spurs/Bone Condition
- ☐Hardening of arteries/Vascular Condition
- ☐Lung/Respiratory Condition
- ☐Blood in stool – Gastrointestinal Condition
- ☐Blood in urine–Genital/Urinary Condition
- ☐Anemia or other blood/lymph related condition
- ☐Herniated disk/Spinal Condition
- ☐Hypertension or Stroke (please circle)
- ☐Depression or Psychiatric Condition (please circle)
- ☐Brain or spinal cord - Neurological Condition
- ☐Blurred vision/Double vision/Eye Condition
- ☐Condition w/ Ears/Nose/Mouth/Throat
- ☐Diabetes or Endocrine Condition Other _____

Have you had any of the following symptoms during the past year? (please check all that apply)

- ☐Dizziness / Ringing in ears / Hearing loss
- ☐Loss of bowel/bladder control
- ☐Night Pain / Severe Night Sweats
- ☐Prolonged use of corticosteroids
- ☐Abdominal pain/pulsations
- ☐Difficulty swallowing
- ☐Slurred speech or other speech problems
- ☐Persistent cough
- ☐Diminished or partial loss of vision
- ☐Temporary lack of understanding
- ☐Numbness or loss of sensation in the face, arms, hands, fingers or legs
- ☐Any other abnormal or loss of sensation in another body part
- ☐Weakness, clumsiness, or strength loss in the face, arms, hands, fingers or legs
- ☐Unexplained weight loss
- ☐Loss of consciousness / Sudden collapse w/out loss of consciousness
- ☐Numbness across the buttocks and groin region
- ☐Other_____

Have you had any of the following childhood diseases:

- ☐Measles
- ☐Rubella
- ☐Chickenpox
- ☐Mumps
- ☐Scarlet Fever
- ☐Rheumatic Fever
- ☐Tuberculosis
- ☐Other _____

Do any diseases run in your family?

_____

_____

Please list any allergies:

_____

_____

_____

Are you under a doctor's care presently for any type of health problem? **Yes No** (please circle)

If yes, please explain:

_____

_____

Have you ever suffered a stroke?

- ☐Yes
- ☐No

Have any relatives ever suffered a stroke?

- ☐Yes
- ☐No

MEN

Date of last prostate exam: _____

Difficulty with urination? **Yes No**

Excessive urination? **Yes No**

Women

Do you take birth control pills? **Yes No**

How long? _____

Do you experience any of the following symptoms: (please circle)

Menstrual pain Cramping Irregularity

Date of last period: _____

Are you pregnant? **Yes No** Due Date: _____

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Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I hereby authorize Sports & Family Chiropractic & Acupuncture llc to furnish information to insurance carriers concerning this illness/accident and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance or Worker's Compensation. Hereby authorize photocopies of this authorization form to be valid as the original. I consent to disclosure of my medical information to outside agencies for the purpose of providing Healthcare Services to me.

Authorization To Release Information (Your Signature is Required)
Do you authorize another person to receive your Medical information? Yes ___No___
IF YES, Who _____ Relationship to Patient _____

Do you authorize another person to receive your Billing information? Yes___ No ___
IF YES, Who _____ Relationship to Patient _____
These authorizations are good until revoked.

X Signature_____ Date_____
(signature of parent if the patient is a minor)

CANCELLATIONS AND NO-SHOWS

Cancellations - Our office policy requires a 24 hour notice for appointment cancellations or rescheduling. We typically have a waiting list of patients who would like to see the doctor. If you cannot make your appointment, please extend the office and other patients the courtesy of giving ample notice so that someone on the waiting list may be seen during that time.
No-Shows - We understand that things do come up and we will try to be as accommodating as possible. But please be aware that a $25 fee will be assessed for no-shows and cancellations without a 24 hour notice.

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Informed Consent to Physical Medicine, Joint Manipulation and Manual Therapy

Please read this entire document prior to signing. It is important that you understand the information it contains. Please feel free to ask questions and to review any information if anything is unclear.

As part of your analysis, examination and treatment, you are consenting to the following procedures

Spinal Manipulative Therapy	Extremity Joint Manipulation	Range of Motion/Neurological Testing
Muscle Strength Testing	Orthopedic Testing	Motion Palpation
Muscular Palpation	Vital Signs	Active Release Techniques (ART)
Electrical Stimulation Therapy	Ultrasound Therapy	Radiographic Studies
Hot/Cold Therapy	Postural Analysis	Kinesio Taping Therapy
Myofascial Release Therapy	Trigger Point Therapy	McKenzie Evaluation/Treatment

The material risk inherent in Active Release Techniques/Myofascial Release Therapy
Active Release Techniques (ART) is a hands-on soft tissue treatment method. You will physically move the region of the body getting worked on through active ranges of motion. ART may be uncomfortable in some regions of the body (like the burn experienced while lifting weights) and may produce soreness post-treatment for up to 1-3 days.

The nature of spinal/extremity joint manipulation
After a full evaluation of your condition, the doctor may make the decision that manipulative therapy would be beneficial to assist your recovery. If joint manipulation is used, the doctor would use his hands in such a way as to move your joints to restore range of motion, proper function and reduce the perception of pain. You may feel a click or pop, similar to someone cracking their knuckles, and you may feel movement of the joint.

The material risk inherent in joint manipulative therapy and ancillary procedures
As with any health care procedure, there are certain complications which may arise following joint manipulation therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscular strain or cervical myelopathy. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke. Some patients will feel some soreness and stiffness following the first twenty four to forty eight hours following their first and/or second treatment utilizing joint manipulation. Your doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to his attention, it is your responsibility to inform him.

The probability of those risks occurring
Fractures are rare occurrences and generally result from some underlying weakness of the bone which is checked for during the taking of your history and during examination and x-ray. Stroke has been a subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical manipulations. The other complications are also described as rare.

The availability and nature of other treatment options
Other treatment options for your condition may include: Self administered, over-the-counter analgesics and rest; Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; Hospitalization or Surgery. If you chose to use one of the other treatment options, you should be aware that there are risks and benefits of such options and you may wish to discuss those with your primary care physician or specialist.

Procedures you would like excluded from your treatment
If there are any procedures previously listed that you would explicitly request not to be employed in your treatment please list these below. We will gladly employ other treatment options to in an attempt to reach the same results.

_____

The risks of and dangers of remaining untreated
Remaining untreated may allow the formation of adhesions and reduced mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

_____ _____
Patient Signature Date

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Trigger Point Dry Needling (TDN) & Acupuncture Consent Form

What is Trigger Point Dry Needling (TDN)?
TDN is an effective therapy to treat muscular tension and spasm which commonly often accompany conditions such as arthritis, nerve irritation, muscular strain, ligament strains and herniated discs. A small, solid filament needle is inserted in a contracted painful knotted muscle to create a local twitch reflex which is the first step to break the pain cycle as research shows will decrease muscle contraction, reduce chemical irritation, improve flexibility and decrease pain.

What is Acupuncture?
Acupuncture is a therapeutic methodology originating in ancient China that treats patients by manipulating thin, solid needles that have been inserted into specific acupuncture points in the skin. According to Traditional Chinese Medicine, stimulating these points can correct imbalances in the flow of qi “Chi” through channels that run throughout the body known as meridians.

Risks of the procedures:
Though unlikely, there are risks associated with any treatment. The most serious risk associated with TDN & Acupuncture is accidental puncture of a lung (pneumothorax) when needling around the thoracic (Upper and Mid Back) region. If this were to occur, it may likely only require a chest x-ray and no further treatment as it can resolve on its own. The symptoms of pain and shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern. If you feel any related symptoms, immediately contact your provider. If a pneumothorax is suspected you should seek medical attention from your physician or if necessary go to the emergency room for a chest x-ray.

Other risks may include bruising, infection and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood, require blood anticoagulants or any other conditions that may have an adverse effect to needle punctures. Bruising is a very common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, significant tissue trauma is rare.

Please consult with your practitioner if you have any questions regarding the treatment above.

- Do you have any known disease or infection that can be transmitted through bodily fluids? Yes___ No___
- Are you pregnant? Yes___ No___
- Do you have a compromised immune system? Yes___ No___
- Are you taking blood thinners? Yes___ No___

If you marked yes, please discuss with your practitioner

Please sign below authorizing your provider to perform TDN/Acupuncture today and future visits

□ **I’d rather not utilize TDN/Acupuncture in my care at any point.**

_____
Please print your name.

_____ _____
Signature Date

CONSENT FOR USE OF PHI FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (HIPPA)

I consent to the use or disclosure of my protected health information (PHI) by **Sports & Family Chiropractic & Acupuncture llc** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that my diagnosis or treatment by the **Sports & Family Chiropractic & Acupuncture llc** staff may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Sports & Family Chiropractic & Acupuncture llc** is not required to agree to the restrictions that I may request. However, if **Sports & Family Chiropractic & Acupuncture llc** agrees to a restriction that I request, the restriction is binding on **Sports & Family Chiropractic & Acupuncture llc**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Sports & Family Chiropractic & Acupuncture llc** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Most uses and disclosures of medical records, uses and disclosures of protected health information (PHI) for marketing purposes, and disclosures that constitute a sale of PHI require patient authorization.

Other uses and disclosures not described in the Privacy Notices will be made only with authorization from the individual.

Patients have the right to restrict certain disclosures of PHI to health plans/insurance companies if the patient pays out of pocket in full for the health care service.

Affected patients have the right to be notified following a breach of unsecured protected health information.

Information transmitted via FAX or Email may be privileged and confidential. There is some risk that any protected health information that may be contained in such transmissions may be disclosed to, or intercepted by, unauthorized third parties. Please be aware that FAX and email communications can be intercepted in transmission or misdirected. Your use of FAX or email to communicate protected health information to us indicates that you acknowledge and accept the possible risks associated with such communication.

I understand I have a right to review **Sports & Family Chiropractic & Acupuncture llc 's** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the clinic. The Notice of Privacy Practices for **Sports & Family Chiropractic & Acupuncture llc** is posted in the reception area. This Notice of Privacy Practices also describes my rights and **Sports & Family Chiropractic & Acupuncture llc's** duties with respect to my protected health information.

Sports & Family Chiropractic & Acupuncture llc reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____	_____	_____
Patient Signature	Printed Name	Date