KB Chiropractic Center

40 Boulevard
Kingston, NY 12401

Dr. Keri Bunbury

Phone: 845-331-8010
Fax: 845-331-8961

Please Sign In and Notify Us:

1. You have a new phone number or address since your last visit.
2. You are now covered by a different insurance policy.
3. You have a new injury or complaint.

RECEPTIONIST FILLS IN GRAY AREA

	Date	Patient Signature	Notes	Ins/ Co-Pay
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12			IS RE-EXAM NEEDED?	
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24			IS RE-EXAM NEEDED?	

Patient:_____ Date:_____

Vital Signs

Wt./ Ht.	
Blood Pressure	
Pulse	
Handedness	
Temperature	

General Inspection/Observation

Edema	
Myofibropathy/Adhesion	
Tight & Tender Fibers	
Spasms	
Pelvic Unleveling	
Shoulder Unlevel	
Weakness	

Posture/Gait

Toe In			
Foot Flare			
Pes Planus			
Genu Varum			
Genu Valgus			
Posterior Heel Wear			

Posture & Asymmetry

Scoliosis		
High Shoulder		
Head Tilt		
Head Rotation		
Head Translation		
Anterior Shoulder		
High Ilium		
Antalgic Lean		
Minor Signs		
Rounded Sh.		
Posterior Ribcage		

Cervical Lordosis	
Upper Thoracic Kyphosis	
Mid Thoracic Kyphosis	
Lumbar Lordosis	

Subluxations:_____

Orthopedic Examination-CERVICAL

Patrick Fabere's Test		
Kemps Test		
Foraminal Compression		
Straight Leg Raises		
Shoulder Depression		
Sicards Sign		

Orthopedic Examination-THORACIC

Adam's Position		
Amoss Sign		
Forestiers Bowstring Sign		
Passive Scapular Approx. Test		
Rib Motion Test		
Schepelmann's Sign		
Sternal Compression Test		

Ortho Exam LUMBAR

Antalgic Sign		
Braggard's Sign		
Cox Sign		
Ely Sign		
Heel Walk		
Toe Walk		
Hyperextension Test		
Kemp's Test		
Lasgue Test		
Linder's Sign		
Milgram's Test		
Nachlas Test		
Sicard's Test		
Lewin Gaenslen's		
Straight Leg Raises		
Rhomberg's Test		

ROM—CERVICAL

Flexion	65	
Extension	50	
L Rotation	85	
R Rotation	85	
L.L. Flexion	40	
R.L. Flexion	40	

ROM—LUMBAR

Flexion	95	
Extension	35	
L Rotation	35	
R Rotation	35	
L.L. Flexion	40	
R.L. Flexion	40	

Neurological Evaluation

Olfactory		
Optic		
Trigem		
Facial		
Acoustic		
Gagistaste		
Swallow		
Tongue		

Physical Examinations

General	
EENT	
LYMPH	
CARDIAC	
ABDOMEN	
EDEMA	

Physical Examinations

SENSORY C5	
SENSORY C6	
SENSORY C7	
SENSORY L5	
SENSORY L4	
SENSORY S1	

KB CHIROPRACTIC CENTER
Dr. KERI BUNBURY

CHILD'S PERSONAL HEALTH HISTORY

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient name: _____ Today's date: _____

Date of Birth: _____ Social Security Number: _____

Name of Parent/Guardian: _____ Phone #: _____

Address: _____

Reason for visit: _____

Previous Chiropractor: _____ Date of last visit: _____

Name of Medical Doctor: _____ Date of last visit: _____

Check any of the following conditions your child has suffered from:

- ☐ Ear infections
- ☐ Asthma/Allergies
- ☐ Colic
- ☐ Scoliosis
- ☐ Digestive problem
- ☐ Bed Wetting
- ☐ Seizures
- ☐ ADHD
- ☐ Car Accident
- ☐ Chronic Colds
- ☐ Constipation
- ☐ Temper Tantrums
- ☐ Headaches
- ☐ Growing/ Back Pains
- ☐ Recurring Fevers
- ☐ Other _____

Number of doses of antibiotics your child has taken:
In the last six months _____ Total during lifetime _____

Please list other prescription medications taken: _____
_____

Vaccination History: _____

Pre-natal History:

Name of Midwife/Obstetrician: _____

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Complications during pregnancy? No / Yes List:_____

Ultrasounds during pregnancy? No / Yes Number: _____
What month(s)?_____

Medications during pregnancy/ delivery? No / Yes List:_____

Cigarette/ Alcohol use during pregnancy? No / Yes Amount:_____

Location of birth: _____
☐ Hospital ☐ Home ☐ Birthing Center

Birth History:

☐ Forceps
☐ Vacuum extraction (Venthouse)
☐ Normal Vaginal
☐ Breech
☐ Caesarian section: Emergency/ Planned

Complications during delivery? No / Yes List:_____

Genetic disorders or disabilities? No / Yes List:_____

Birth weight: _____ Birth Length: _____ APGAR Scores: _____

Feeding History:

Breast fed: No / Yes How long: _____

Has your child fed well off one breast/ side in preference to the other? _____

Formula fed: No / Yes How long: _____

Brands / Types of formula used: _____

Introduced to Solids at: _____ months. Cows milk at _____ months.

Food / Juice Allergies or Intolerances? List: _____
_____

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During the following times your child's spine is most vulnerable to stress and should be routinely checked by a doctor of chiropractic for prevention and early detection of vertebral subluxations (spinal nerve interference). At what age was your child able to:

_____Respond to Sound
_____ Respond to Visual Stimuli
_____ Hold Head Up
_____ Sit Up
_____Cross Crawl
_____ Stand Alone
_____ Walk Alone

According to the US National Safety Council, approximately 50% of children fall headfirst from a high place during their first year of life (i.e. from a bed, changing table, down stairs, etc.). Was this the case with your child? NO / YES

Is / has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.) NO / YES
List: _____
_____

Has your child ever been involved in a Car Accident? NO / YES, List: _____

Has your child ever been seen on an emergency basis? NO / YES, List:_____

Other traumas not noted above? NO / YES, List: _____

Prior surgery? NO / YES, List: _____
_____

Menarche? NO / YES, Age:_____

Number of hours sleep per night _____ Quality of sleep: GOOD FAIR POOR

Are there any positions your baby does not like lying in? (eg. Lying on back, etc.)
_____

Has your child been diagnosed as having Congenital Hip Dislocation (Clicky Hips)? NO / YES

Pets: _____ How long? _____

Childhood Diseases:

Chicken Pox	N / Y, Age _____
Rubella	N / Y, Age_____
Rubeola	N / Y, Age _____
Mumps	N / Y, Age _____
Whooping Cough	N / Y, Age_____
Other	N / Y, Age_____

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Is there any other information you would like for us to know?

_____

_____

_____

We are here to serve you, and encourage you to ask questions. Your participation is vital and will help determine your results.

So that the doctor may provide you with the highest quality of care, please list any medications/vitamins/or mineral supplements that you are currently taking. The doctor keeps this in consideration throughout your care and uses a professional opinion to let you know if she thinks you should be taking more or less dosage of a supplement.

Medication/Supplement	Dosage	Times/Daily

As a patient in our office, our primary goal is to help you reach a state of wellness and health. In order to do so, we ask for your permission to contact your primary care physician or another doctor if deemed necessary, to state the conditions in which we are treating you for. This is so they may know and incorporate your treatment into any diagnosis or treatment they provide to you. By involving your primary doctor in your care, we allow for comprehensive treatment and thus a higher level of wellness for you.

Primary Care Physician _____ Office Location_____

Other Preferred Doctor _____ Location _____

I, _____, authorize KB Chiropractic Center to correspond with the above-stated doctor(s) regarding my diagnosis, treatment, and health conditions.

Signature: _____ Date: _____

KB Chiropractic
40 Boulevard
Kingston, NY 12401

Innate Empowerment Corporation

Fee For Service Qualification

phone: 845.331.8010
fax: 845.331.8961

KB Chiropractic Office Policies

1. Our fees for service are the same for all patients, whether or not they are covered by insurance, except in the case of a hardship.
2. All payments are expected at the time of service or by the last visit of each week. No patient balance may ever exceed $150.00 at any given time.
3. Whether cash or insurance patient, it is your understanding that anything insurance does not cover becomes patient responsibility.
4. In the event that you discontinue care prior to the doctor's recommendation, you are responsible to pay in full any outstanding balances within 10 business days.
5. If you are unable to keep an appointment for any reason, we require that you provide us with at least 24 hours notice. Emergencies, of course, are an exception.
6. We require that you sign-in at the front desk upon arrival at each visit as we attempt to honor all appointments at their scheduled times. If you arrive late or early, you may have to wait for the next available appointment time.
7. We reserve the right to charge $25.00 for missed appointments without prior notification.
8. If you are seeking maximum health benefits from chiropractic care in our office, we recommend that you follow the doctor's treatment plan.

We request that you sign this form as verification that you have read, understand and agree to comply with this policy.

Fee For Service Patients: I understand that ultimately I am financially responsible for the professional service rendered. I understand that I will receive a treatment plan that states the commitment required for the doctor to treat said condition(s). I also understand that this is a contract between KB Chiropractic and I; I have read the policies listed above and understand those policies.

Patient/Legal Guardian: _____ Date: _____

Insured Patients: I understand that this office verified my insurance benefits as a courtesy to me and that it is not a guarantee of benefits. I also understand that the quoted information does not release me from any financial responsibility to this office and that I am responsible for denial of benefits.

Patient/Legal Guardian: _____ Date: _____

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Terms of Acceptance

When an individual or family seeks and is accepted for chiropractic care, it is essential for all parties involved to be working towards the same objective.

Chiropractic has only one goal. It is important that everyone understands both the objectives and the method that will be used to achieve it. This will prevent any confusion or disappointment.

Health: A dynamic state of wholeness in which your body can accurately perceive its constantly changing needs and respond appropriately in a timely manner. In short, Health is the ability to adapt to both internal and external stresses, whether they are physical, chemical or emotional.

Subluxation Process: A downward spiral in an individual's health and vitality as the result of a disruption in the normal flow of energy in the nerves between the brain and the cells of the body. This leads to a lack of health, or the inability of the body to adapt.

Chiropractic Adjustment Process: A program that employs the progressive and specific application of a gentle force to facilitate the body's correction of the subluxation process and restore its innate adaptive healing process so as to progressively bring about a state of health and wholeness.

We do not offer to diagnose or treat any disease or condition other than the subluxation process. However, if during the course of a chiropractic evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment of those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the "disease" is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the full expression of your body's healing capabilities. Our only method is specific adjusting to correct the subluxation process.

I, _____ have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I understand the terms of acceptance and would like to participate as a patient in this office.

I therefore, accept chiropractic care on this basis from KB Chiropractic Center.

_____ (Signature)

_____ (Date)

General Consent for Care and Treatment Consent

KB CHIROPRACTIC
DR. KERI BUNBURY
CERTIFIED CHIROPRACTIC SPORTS PHYSICIAN
PH: 845-331-8010 •
40 BOULEVARD KINGSTON, NY 12401

To The Patient: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request Dr. Keri to perform reasonable and necessary medical examinations, testing and treatment for the condition which has brought me to seek care at this practice.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____