PATIENT PERSONAL/CONFIDENTIAL DATA

No.________________ **Date:** ________________

Patient:________________ **Date of Birth:** ________________

Home Address:________________ **City:**________________ **State:**______ **Zip:** ________

Social Security No.:________________ **Home Phone:**________________ **Work Phone:**________________

Employer:________________ **Address:** ________________

Name of Spouse:________________ **SS No.:**________________ **No. of Children:** ________

Spouse's Employer:________________ **Address:**________________ **Marital Status:** ________

How did you learn of this clinic? ________________

Nearest relative not living with you?________________ **Phone:** ________________

Who is responsible for payment? ❑ Self ❑ Spouse ❑ Other:________________

PRIMARY INSURANCE:	SECONDARY INSURANCE:
Insured: ________________	Insured ________________
Name of Company: ________________	Name of Company: ________________
Address: ________________	Address: ________________
ID & Group No.: ________________	ID & Group No.: ________________
Phone No.: ________________	Phone No.: ________________

Purpose of this appointment and list your complaints: ________________

____

Date of illness: ________ Time: ________ ❑ AM ❑ PM Location: ________________

How did accident occur? ❑ Auto ❑ On the job ❑ Other: ________________

Please describe the circumstances and what makes the condition(s) better or worse: ________________

____

____

____

Other Doctor seen for this condition: ________________

Have you been treated by a Doctor for any health condition in the last year? ❑ Yes ❑ No

If yes, please describe: ________________

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature Physician: ________________ Signature Patient: ________________

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) records to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient's Signature: ________________

Parent's or Guardian's Signature: ________________

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOUR ARE CURRENTLY EXPERIENCING OR HAVE EXPERIENCED IN THE PAST

Date: ______________________

Patient: ____ No.: ______________________

MUSCULOSKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Spasms
- ❑ Broken bones
- ❑ Shoulder pain

GENITO-URINARY SYSTEM

- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine
- ❑ Prostate problems

FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps in the breast

ARE YOU PREGNANT?
❑ YES ❑ NO

GASTRO-INTESTINAL SYSTEM

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Difficult swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble
- ❑ Acid reflex

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscles jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia

HABITS

- ❑ Cigarettes
- ❑ Alcohol Abuse
- ❑ Coffee or Tea
- ❑ Exercise
- ❑ Drug Abuse
- ❑ ______________

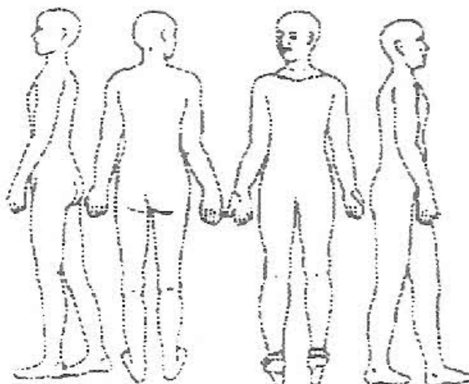
CARDIO-VASCULAR SYSTEM

- ❑ Pacemaker
- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficult breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose veins

EYE, EAR, NOSE AND THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficult breathing thru nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw pain

SYMPTOM LOCALIZATION



P ___ Pain   T ___ Tender
N ___ Numb   H ___ Hypoesthesia
S ___ Spasm

Pain Index
Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature: ______________________

List Medications: ____

____

List Surgeries: ____

____

Patient Accepted? ❑ Yes ❑ No   Doctor's Signature: ______________________

Aitkens Family Chiropractic 13047 Kansas Ave., Bonner Springs, KS 66012 (913) 441-4050

AITKENS FAMILY CHIROPRACTIC CENTER, P.A.

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (entities that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

It is the practice of this office to use sign-in sheets that are visible and accessible to patients, staff and others who may enter this office.

It is the practice of this office to display patient names on our patient referral board.

It is the practice of this office to display pictures of children on our "Kids wall".

It is the practice of this office to use your name, address and/or telephone number(s) for the purpose of contacting you regarding appointment related issues, referrals and office mailings.

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. An "open- adjusting" approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open. As a result, patients are occasionally within sight and sound of one another and some ongoing routine details of care are discussed with staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting report of findings. These procedures are completed in a private, confidential setting.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance our access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment, other arrangements will be made for you. Your decision will have no effect on your care at our office or on your relationship with our staff.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

(OPTIONAL) I authorize the release of my medical information to:

____ Relationship____________________________

(PLEASE PRINT NAME)

Patient Name:____

(PLEASE PRINT NAME)

Signature: ______________________________________ Date__________________________

(Patient / Patient's Representative)

____

(Relationship to Patient)

CONFIDENTIAL