



15545 West 87th Street, Lenexa, K 66219
Tel. (913) 894-4428 • Fax (913) 894-4427
www.kcspineandsport.com

Patient Information

Date: ____ / ____ / ____
Name: _____
Address: _____
City: _____ State: ____ Zip: ____
Date of Birth: _____ Age: ____
SSN: ____ / ____ / ____ Gender: Male Female
Marital Status: Married Single Other
How did you hear of this center?

Height: _____ Weight: _____
Females: Are you pregnant? Yes No
Number of kids: _____
Primary Doctor: _____
May we contact if necessary? Yes No
Occupation: _____
Employer: _____

Conditions

What condition are you here for today and what caused it?

Is this condition: Chronic Auto Accident
Job Related Sports Injury
When did symptoms begin? _____
Has this occurred before? Yes No
If yes, when? _____
What makes your pain feel:
Better? _____
Worse? _____
Ever been in a collision? Yes No
Previous chiropractic care? Yes No
If yes, when? _____

Contact Information

Home phone: _____
Cell phone: _____
Work phone: _____ Ext: _____
Email: _____ @ _____
Best way to reach you:
Home Cell Work Email

Emergency Contact

Name: _____
Relationship: _____
Address: _____
City: _____ State: ____ Zip: ____
Phone: _____

Spouse Information

Name: _____
Address: _____
City: _____ State: ____ Zip: ____
DOB: ____ / ____ / ____ SSN: ____ / ____ / ____
Phone #: _____

Health Habits

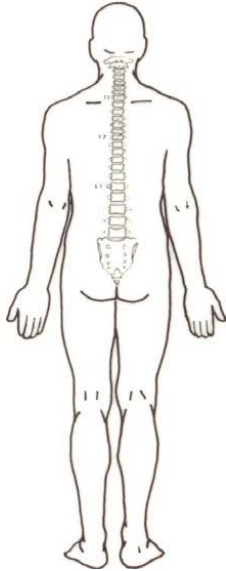
Smoke? Yes No Amount: _____
Drink alcohol? Yes No Amount: _____
Drink pop? Yes No Amount: _____
Drink coffee? Yes No Amount: _____
Exercise? Yes No Amount: _____
Water? Yes No Amount: _____
Please list all medications:

Please list all supplements:

List any major surgeries or hospitalizations:

Severity of pain: (1=Least, 10=Greatest)

Select region of pain and circle severity number
 Burning • Stabbing • Sharp • Constant



EXAMPLE: NECK *SHARP*

1 2 3 4 5 6 7 **8** 9 10

NECK _____
 1 2 3 4 5 6 7 8 9 10

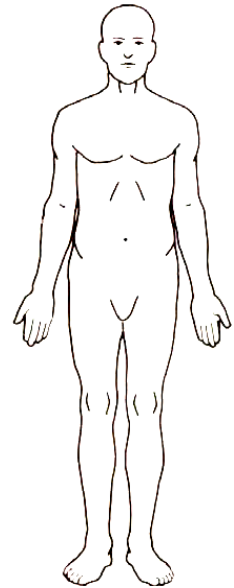
MID BACK _____
 1 2 3 4 5 6 7 8 9 10

LOW BACK _____
 1 2 3 4 5 6 7 8 9 10

HIPS _____
 1 2 3 4 5 6 7 8 9 10

ARMS _____
 1 2 3 4 5 6 7 8 9 10

LEGS _____
 1 2 3 4 5 6 7 8 9 10



Please draw on the figures where you have any of the following:
 A= Ache SF= Stiffness SH= Sharp S= Soreness
 N= Numbness P= Pain C= Constant XX= Other

Please check if you have currently or have had any of these conditions:

GENERAL

- Convulsions
- Loss of Sleep
- Fatigue
- Nervousness
- Loss of weight
- Numb in arms/legs/hands
- Neuralgia
- Diabetes I
- Diabetes II
- Cancer
- Anemia
- Arthritis
- Depression
- Thyroid/Goiter
- Spine Trauma
- Whiplash
- Scoliosis
- Ulcers

MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain in shoulders
- Shoulder pain
- Neck pain
- Stiff neck

FAMILY HISTORY

Please list if any of the following have affected a family member: Diabetes • Heart • Cancer • Kidney • Back

Mother: _____
 Father: _____
 Brother(s): _____
 Sister(s): _____

- Swollen joints
- Painful joints
- Arm problems
- Leg problems
- Sore muscles
- Foot Problems
- Walking problems
- Weak muscles
- Muscle Spasm

GASTRO-INTESTINAL

- Poor Appetite
- Excessive Hunger
- Difficult Chewing
- Difficult Swallowing
- Nausea
- Vomiting Blood
- Abdominal Pain
- Diarrhea
- Constipation
- Bloody Stools
- Liver Trouble
- Gall Bladder Problems
- Excessive Thirst
- Hemorrhoids

EYE/EAR/NOSE & THROAT

- Eye Inflammation
- Vision Problems
- Ear Pain
- Hearing Loss
- Dental Problems
- Hoarseness
- Difficult Speech
- Sinus
- Allergy
- Jaw Pain

NERVOUS SYSTEM

- Numbness
- Tingling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle Jerking
- Convulsions
- Insomnia

GENITO-URINARY SYSTEM

- Excessive Urination
- Light Urination

- Painful Urination
- Bed Wetting
- Prostate Trouble
- Kidney Infection

CARDIO-VASCULAR

- Chest Pain
- Difficult Breathing
- Persistent Cough
- Coughing Phlegm
- Coughing Blood
- Rapid Heart Beat
- Slow Heart Beat
- High Blood Pressure
- Low Blood Pressure
- Swelling Ankles
- Poor Circulation
- Varicose Veins
- Stroke
- Pacemaker
- Palpitations
- Lung Problems

FEMALES ONLY

- Vaginal Discharge
- Vaginal Bleeding
- Vaginal Pain
- Breast Pain

AUTHORIZATION

X _____ DATE: _____ DOB: ____/____/____

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THIS NOTICE DESCRIBES HOW HEALTH RELATED
INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW
YOU GET ACCESS TO THIS INFORMATION.

PATIENT NAME: _____ DATE: ____/____/____
DOB: ____/____/____

BILLING 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 all balances must be paid within 90 days. Any balances over 90 days will be charged \$5.00 per month unless prior arrangements for payment have been made. I also agree that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I agree to be held responsible for any returned check fee of \$30.00.

RELEASE OF INFORMATION CONSENT

I give authorization to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under contract to the clinic or to the patient or to a family member or employer of the patient for all or part to the clinic's charge, including and not limited to hospital or medical services companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

In the course of your care as a patient at our office, we may use or disclose personal and health related information about you in the following ways: 1) Your personal health information (PHI), 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. 2) Your health records, as well as your billing records may be disclosed to another party, such as an insurance carrier (HMO, PPO, Automobile Insurance, etc.) or your employer (if they are responsible for payment). 3) Your name, address, phone number and you health records may be used to contact you regarding appointment reminders or provide information about alternatives to your present care. If you are not at home to receive an appointment reminder, a message may be left on your answering machine. 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. Under federal law, we are permitted to use or disclose you PHI without your consent or authorization in the following circumstances:

- ❖ If we are providing health care services to you based on the orders of another health care provider.

- ❖ If we provide 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 judgment we believe that you intend for us to provide care.

We normally provide information about your health care to you in person at the time you receive chiropractic from us. We may also mail information to you regarding your health care or about the status of your account.

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare and necessary reports and forms to assist me in making collections 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 that if I suspend to terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I agree to be held responsible for any returned check at a fee of \$30.00.

CONSENT FOR PROFESSIONAL SERVICES

I hereby request and consent to the performances of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named above, for whom I am legally responsible) by the doctor of chiropractic named about and/or other licensed doctors of chiropractic who now or in the future work at the clinic. I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocation and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this content form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT NAME: _____ DATE: ____/____/____
 SIGNATURE: _____ DOB: ____/____/____