CHIROPRACTIC REGISTRATION AND HISTORY

Andover Family Chiropractic
215 S. Andover Rd, Suite E
Andover, KS 67002
(316) 733-0715

1 PATIENT INFORMATION

Today's Date: ___/___/ 20___ Birth Date: ___/___/___

Patient Name_____
Last Name

_____
First Name Middle Initial

Address_____

City_____State_____Zip_____

Sex: □ M □ F Age____ SS # _____-_____-_____

□ Married □ Widowed □ Single □ Divorced □ Minor

Patient Occupation_____

Employer/School_____

Employer/School Phone (_____)_____

RESPONSIBLE PARTY

Name _____

Relationship to patient_____Phone (___)_____

Address_____

City_____State_____Zip_____

2 INSURANCE INFORMATION

Primary Insurance Co. _____

Policy Holders Name _____

Relationship to Patient_____DOB____/____/____

Subscriber's SS #_____-_____-_____ Male / Female

Policy #_____Group # _____

Is patient covered by additional insurance ? □ Yes □ No

Second Insurance Co. _____

Policy Holders Name _____

Relationship to Patient_____DOB____/____/____

Subscriber's SS #_____-_____-_____ Male / Female

Policy # _____Group # _____

3 CONTACT INFORMATION

Cell Phone: (_____) _____-_____

Home Phone: (_____) _____-_____

Email_____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship _____

Home Ph.(___)_____Work Ph.(___)_____

Primary Physician _____

May we send your physician notes about your care? Y N

4 ACCIDENT INFORMATION

Is Condition due to an accident ? □ Yes □ No Date _____

Type of accident □ Auto □ Work □ Home □ Other

To whom have you made a report of your accident ?
□ Auto Insurance □ Employer □ Works Comp □ Other

Attorney Name (if applicable) _____

5 Current Medications, Vitamins, Minerals, Herbs Taken for:

_____

_____

_____

_____

_____

_____

Rendering Provider Dr. Kevin Allen D.C.

Patient Name _____ Date_____

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HEALTH HISTORY

What treatment have you already received for your condition ? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor (s) who have treated you for this condition _____

Date of last: Physical Exam _____ Spinal X-Ray _____ Spinal Exam _____
Chest X-Ray _____ MRI, CT Scan, Bone Scan _____

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

AIDS/HIV ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Migraine Headaches ☐ Yes ☐ No	Psoriatic Disorders ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Psychiatric Care ☐Yes ☐ No
Appendicitis ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Rheumatoid Arthritis ☐Yes ☐ No
Arthritis ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Rheumatic fever ☐Yes ☐ No
Asthma ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Numbness ☐ Yes ☐ No	Seizures ☐ Yes ☐ No
Biopolar Disorder ☐ Yes ☐ No	Headache ☐ Yes ☐ No	Osteoarthritis ☐ Yes ☐ No	Scoliosis ☐ Yes ☐ No
Bleeding Disorders ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Spinal Fracture ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Pancreatic Disease ☐ Yes ☐ No	Thyroid Problem ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Parkinson's Disease ☐ Yes ☐No	Tonsillitis ☐ Yes ☐ No
Chemical	High Cholesterol ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐No	Tuberculosis ☐ Yes ☐ No
Dependency ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Tumors, Growths ☐ Yes ☐ No
COPD ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Depression ☐ Yes ☐ No	Memory Loss ☐ Yes ☐ No	Prostate Problem ☐Yes ☐ No	Vertigo ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No	Metal Implants ☐ Yes ☐ No	Prosthesis ☐ Yes ☐ No	**Oth-er**_____

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking Packs/Day_____
- ☐ Alcohol Drinks/Week_____
- ☐ Coffee/Caffeine Drinks Cups/Day_____
- ☐ High Stress Level Reason_____

Are you pregnant ? ☐ Yes ☐ No Due Date _____

Past Injuries/Surgeries: Description Date

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES

_____
_____
_____

I certify that the above information to be complete and accurate:

Print Name	Relationship / Authority to Patient	Signature	Date
_____	_____	_____	_____

Rendering Provider Dr. Kevin Allen D.C.

Describe the reason for your visit today: _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes your problem most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above problem at the above intensity: 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- Did the problem begin suddenly or gradually? (circle one) SUDDENLY GRADUALLY
- When did the problem begin? _____
- How did the problem begin? _____
- What makes the problem worse? (circle all that apply):
    - Nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed,
    - Other (please describe): _____
- What makes the problem better? (circle all that apply):
    - Nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage,
    - Other (please describe): _____
- Describe the quality of the problem (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    - Other (please describe): _____
- Does the problem radiate to another part of your body (circle one): YES NO
    - If yes, where does the symptom radiate? _____
- Is the problem worse at certain times of the day or night? (circle all that apply)
  No difference Morning Afternoon Evening Night Other: _____
- Have you received treatment for this condition and episode prior to today's visit? (check all that apply)

☐ No treatment	☐ Cortisone injections
☐ Anti-inflammatory meds	☐ Surgery
☐ Pain medication	☐ Massage
☐ Muscle relaxers	☐ Physical Therapy
☐ Trigger point injections	☐ Chiropractic

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Rendering Provider: Dr. Kevin Allen D.C.

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Ph: (316) 733-0715 Fax: (316) 733-5014 Web: drkevinallen.com

INFORMED CONSENT TO TREATMENT:

I do hereby give my consent to conservative, noninvasive treatment to the joints and soft tissues. I understand that treatments in this office may consist of chiropractic adjustments, chiropractic manipulations, therapeutic and rehabilitative exercise, electrical therapy, ultrasound therapy, muscle/soft tissue release, diagnostic testing, and other therapeutic modalities may also be used as listed below by Dr. Kevin Allen, D.C. on me (or the patient named below for whom I am legally responsible). I understand that there are beneficial effects associated with the treatment procedures used in this office, however, as with any medical procedure or therapy, there is no certainty that I will achieve these benefits. Reasonable alternatives to these procedures include rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

* Decompression Therapy	* Nutritional Recommendations	* Interferential Muscular Stimulation
* Fascia/Percussion Therapy	* Acupuncture	* Rehabilitation Exercises
* Ultrasound	* Kinesio-Taping Methods	* X-ray imaging

Although spinal manipulation/adjustment is considered to be one of the safest, most effective treatments for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: It is common to experience muscle soreness in the first few treatments. Symptoms may worsen for a short period before they improve.

Dizziness: Temporary symptoms like dizziness, headache, and nausea can occur but are relatively rare.

Fractures/Joint Injury: In isolated cases underlying deformities or pathologies (ie: osteoporosis) may render the patient susceptible to injury.

When osteoporosis, degenerative disc, or other abnormalities are detected, this office will proceed with extra caution.

Stroke: Strokes from chiropractic adjustments are extremely rare. I am aware that stroke occurs once in 1-10 million adjustments.

Unusual Findings: If non-chiropractic or unusual findings are encountered, I will be referred to another healthcare provider.

PAYMENTS & INSURANCE: I request payment of authorized insurance benefits to be made on my behalf to Dr. Kevin D. Allen D.C. dba Andover Family Chiropractic for any services furnished to me. I authorize release of any medical information concerning me to your company and its agents any information needed to determine these benefits or benefits payable for related services. I also agree to pay this bill in full for any unrecovered services by my insurance company. My insurance is billed by this office as a courtesy to me and the benefits quoted are not a guarantee of payment.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare Benefits including Medigap benefits be made on my behalf to Dr. Kevin D. Allen D.C. for any services rendered to me by that physician. I authorize any holder of medical information about me to be released to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for these services. This authorization applies to all services until it is revoked by me or my representative.

CONSENT TO EVALUATE & TREAT: I have read, or have had read to me, the above explanation of chiropractic treatment and office policies, and have had an opportunity to ask questions about its contents, and by signing below, I (or the patient named below for whom I am legally responsible) agree to the treatment recommended by my physician, I also understand said policies. I (or the patient named below for whom I am legally responsible) intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility. If at any time, I decide to decline these statements I will do so in writing in advance of treatments and present the written document of decline of these specific treatments to Andover Family Chiropractic or to Dr. Kevin D. Allen D.C.

Print Patient's Name	Printed Name of Responsible Party	Signature of Responsible Party	Today's Date

Rendering Provider: Dr. Kevin Allen D.C. DOB:

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HIPAA & COMMUNICATION

By signing this form, you will consent to our office using and disclosing your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to have a copy of and to read our Notice of Privacy Practices prior to signing this form. It describes treatment, payment, and healthcare operations and the use of your information. We reserve the right to change our Privacy Practices. A revision notice will be provided upon change. A copy of our Privacy Practice may be obtained at any time by asking the front desk staff.

You have the right to revoke this Consent at any time by giving written notice to our office. Please note that we may decline to treat you if you decline this Consent.

I have read and understand the content of the privacy consent form. I give my consent for this office to use and disclose my personal health information for treatment, payment activities, and healthcare operations.

I understand that patient care takes place in an open area. Any conversations I have with the doctor could be overheard by other patients. If I have a confidential matter I wish to discuss, time will be scheduled for me to speak to the doctor privately.

COMMUNICATION: I agree to permit Andover Family Chiropractic and their business associates to contact me, and all other responsible parties on my account, on our cell phone, email, or other mobile devices concerning any and all aspects of my account.

I am authorizing the personnel at Andover Family Chiropractic to leave medical information and test results with others if I am not available.

Please be advised that we cannot speak with anyone that is not listed on this form. This includes spouses, children, and caregivers.

Name: _____

Relationship to patient: _____

Phone number: _____

Name: _____

Relationship to patient: _____

Phone number: _____

Print Patient's Name: _____

_____ Patient's Signature

_____ Signature of Parent / Guardian

____/____/____ Today's Date

Rendering Provider: Dr. Kevin Allen D.C.	DOB: