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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6 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 :

Condition		Condition		Condition		Condition	
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 Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐No	Tuberculosis	☐ Yes ☐ No
COPD	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Memory Loss	☐ Yes ☐ No	Prostate Problem	☐Yes ☐ No	Vertigo	☐ Yes ☐ No
		Metal Implants	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	**Other** __________	

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day __________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week __________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day __________
☐ Heavy	☐ Heavy Labor	☐ 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.

Patient Name: ____ **Date:** ___________

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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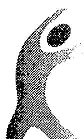
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Informed Consent, Payment, PHI

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, ultra sound 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).

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

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.

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: Like exercise, it is common to experience muscle soreness in the first few treatments. In some cases, symptoms may get worse for a short period before they get better.

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.

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

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. I agree to the use of these procedures. Reasonable alternatives to these procedures include rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

PROTECTED HEALTH INFORMATION (PHI)

I understand this office cannot release my PHI without my written consent and cannot be shared with anyone else unless I give prior written authorization. Occasionally my PHI could be overheard by other patients in the office. I understand I can request a copy of my records. My PHI may be shared in consultation with another healthcare provider. My PHI is required for billing and payments for and by third party payers. A full HIPAA manual is available to me to review in this office, at any time. All staff have been trained in the importance of patient record privacy.

PAYMENTS, INSURANCE & IDENTIFICATION

I understand: I am fully responsible for all fees for services and goods. I request payment from my insurance company to be made to this office. I am responsible for all deductibles, copayments and any charges not covered by my insurance company. All payments are due at time of service. My insurance is billed by this office as a courtesy to me and the benefits they quote are not a guarantee of payment. Any outstanding unpaid balance on my account may be turned over to a collection agency and I am further responsible for all costs and fees for such. This office will keep a copy of my insurance card and drivers license which will be used strictly for insurance and identification purposes.

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 agree to the treatment recommended by my physician, I also understand said policies. I 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	**Relationship / Authority to Patient**	**Signature**	**Today's Date**

Rendering Provider: Dr. Kevin Allen D.C.

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

______________________	______________________	__________
Print Patient's Name	Patient's Signature	Date

MINORS: If patient is a minor or under a guardianship order as defined by State law:

______________________	______________________	__________
Print Patient's Name	Signature of Parent / Guardian	Date

____________________**(initials)** I have seen the copy of the take home Office HIPAA and I opt not to take a copy at this time. I can receive a copy at any time in the future, upon request. A copy of the take home Office HIPAA can also be viewed on our practice website at www.drkevinallen.com.

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Consent for Communication With Patient:

I consent to all communication with Kevin D. Allen Family Chiropractic, LLC doing business as Andover Family Chiropractic, including but not limited to communication about my medical condition and advice from my health care providers by the following means: (check all that you consent to)

- ☐ Text
- ☐ Email
- ☐ Voicemail
- ☐ I do NOT consent to any voicemail, email or texting communication

Consent for Communication With Others:

I hereby authorize the physicians and staff of Kevin D. Allen Family Chiropractic, LLC doing business as Andover Family Chiropractic, to give the following people information concerning my health and well being.

Name: ____________________

Relationship to patient: ____________________

Phone number: ____________________

Name: ____________________

Relationship to patient: ____________________

Phone number: ____________________

The following information may be given to the above individuals:

- ☐ Appointment Time
- ☐ Test / Lab Results
- ☐ Treatments / Therapies
- ☐ Any other information regarding my health

I understand I may revoke this consent at any time by giving written notice to the person or organization making this disclosure. This authorization expires upon written notification from the patient to alter the document.

____________________	____________________	____________________	__________
Print Patient's Name	**Relationship or Authority to Patient**	**Signature**	**Date**

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