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: ____/____/____ 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. 1972508166

Patient Name _____ Date_____

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

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	**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. 1972508166

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
  - ☐ Anti-inflammatory meds
  - ☐ Pain medication
  - ☐ Muscle relaxers
  - ☐ Trigger point injections
  - ☐ Cortisone injections
  - ☐ Surgery
  - ☐ Massage
  - ☐ Physical Therapy
  - ☐ Chiropractic

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

Rendering Provider: Dr. Kevin Allen 1972508166

Andover Family Chiropractic
215 S. Andover Road, Suite E, Andover, KS 67002
Ph: (316) 733-0715 Fax: (316) 733-5014 Web: drkevinallen.com

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 A MINOR CHILD

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care by the doctor and/or staff.

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 Name	Relationship / Authority to Patient	Signature	Date

Rendering Provider: Dr. Kevin Allen 1972508166

PERMISSION TO GIVE MEDICAL INFORMATION

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.

_____ Spouse Name: _____

_____ Significant Other Name: _____

_____ Any specified person Name: _____

_____ Any specified person Name: _____

Following forms of communication are ok:

_____ home telephone/answering machine, please provide number _____

_____ work telephone/answering machine, please provide number _____

_____ cellular phone including texts, please provide number _____

The following information may be given to the above individuals:

_____ Appointment Time

_____ Test/Lab Results

_____ Procedures

_____ 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.

Signed: _____ Date: _____
(patient/parent/legal guardian)

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

Rendering Provider: Dr. Kevin Allen 1972508166

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

_____ _____
Print Patient's Name Date

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.

_____ _____
Patient's Signature Date

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

_____
Signature of Parent / Guardian

_____**(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.

Andover Family Chiropractic
215 S. Andover Road, Suite E, Andover, KS 67002
(316) 733-0715 Fax (316) 733-5014

Rendering Provider: Dr. Kevin Allen 1972508166