

CONFIDENTIAL HEALTH INFORMATION

Swickard Chiropractic Clinic Chtd.
Dr. Bruce Swickard
Dr. Nicholas Swickard
15050 Antioch Road Ste 102
Overland Park, KS 66221
913-897-6717

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

☐ No ☐ Yes When?

Whom may we thank for referring you?

Gender

☐ Male ☐ Female

If so, whom?

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Age

Marital Status

☐ Single ☐ Married ☐ Divorced

☐ Widowed ☐ Separated

Address

City

State/Province

ZIP/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

May we contact you at work?

☐ Yes ☐ No

Preferred method of contact?

☐ Home Phone ☐ Cell Phone

☐ Work Phone ☐ Email

Address

City

State/Province

ZIP/Postal Code

Work Phone

Insurance Carrier

Policy Number

Primary Care Provider's Name

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

☐ Self ☐ Spouse ☐ Parent

First Name

Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

PAGE
1/4

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1. The symptom(s) that have prompted me to seek care today include: _____

Patient name _____

2. And are the result of (darken circle): ☐ An accident or injury

☐ Work ☐ Auto ☐ Other _____

☐ A worsening long-term problem

☐ An interest in: ☐ Wellness ☐ Other _____

3. Onset (When did you first notice your current symptoms?) _____

4. Intensity (How extreme are your current symptoms?)

0 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 10
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)

☐ Constant ☐ Comes and goes. How Often? _____

6. Quality of symptoms (What does it feel like?)

☐ Numbness

☐ Tingling

☐ Stiffness

☐ Dull

☐ Aching

☐ Cramps

☐ Nagging

☐ Sharp

☐ Burning

☐ Shooting

☐ Throbbing

☐ Stabbing

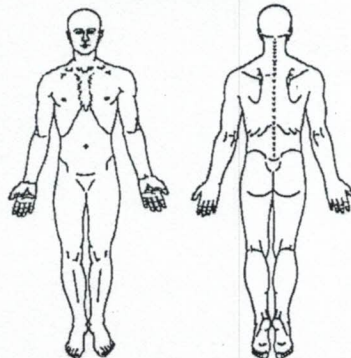
☐ Other _____

7. Location (Where does it hurt?)

Circle the area(s) on the illustration.

"0" for current condition

"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.) _____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

☐ Prescription medication ☐ Surgery ☐ Ice

☐ Over-the-counter drugs ☐ Acupuncture ☐ Heat

☐ Homeopathic remedies ☐ Chiropractic ☐ Other _____

☐ Physical therapy ☐ Massage _____

11. What else should Dr. Swickard know about your current condition? _____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE ☐
☐ Osteoporosis	☐ Arthritis	☐ Scoliosis	☐ Neck pain	☐ Back problems	☐ Hip disorders	Initials _____
☐ Knee injuries	☐ Foot/ankle pain	☐ Shoulder problems	☐ Elbow/wrist pain	☐ TMJ issues	☐ Poor posture	

b. Neurological

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE ☐
☐ Anxiety	☐ Depression	☐ Headache	☐ Dizziness	☐ Pins and needles	☐ Numbness	Initials _____

c. Cardiovascular

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE ☐
☐ High blood pressure	☐ Low blood pressure	☐ High cholesterol	☐ Poor circulation	☐ Angina	☐ Excessive bruising	Initials _____

d. Respiratory

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE ☐
☐ Asthma	☐ Apnea	☐ Emphysema	☐ Hay fever	☐ Shortness of breath	☐ Pneumonia	Initials _____

e. Digestive

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE ☐
☐ Anorexia/bulimia	☐ Ulcer	☐ Food sensitivities	☐ Heartburn	☐ Constipation	☐ Diarrhea	Initials _____

f. Sensory

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE ☐
☐ Blurred vision	☐ Ringing in ears	☐ Hearing loss	☐ Chronic ear infection	☐ Loss of smell	☐ Loss of taste	Initials _____

g. Skin

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE ☐
☐ Skin cancer	☐ Psoriasis	☐ Eczema	☐ Acne	☐ Hair loss	☐ Rash	Initials _____

Consultation Notes

Doctor's Initials

Swickard Chiropractic Clinic Chld

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PAGE 2/4

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(Continued from previous page)

h. Endocrine

Had Have Had Have Had Have Had Have Had Have Had Have NONE ☐
☐ ☐ Thyroid issues ☐ ☐ Immune disorders ☐ ☐ Hypoglycemia ☐ ☐ Frequent infection ☐ ☐ Swollen glands ☐ ☐ Low energy Initials _____

i. Genitourinary

Had Have Had Have Had Have Had Have Had Have NONE ☐
☐ ☐ Kidney stones ☐ ☐ Infertility ☐ ☐ Bedwetting ☐ ☐ Prostate issues ☐ ☐ Erectile dysfunction ☐ ☐ PMS symptoms Initials _____

j. Constitutional

Had Have Had Have Had Have Had Have Had Have NONE ☐
☐ ☐ Fainting ☐ ☐ Low libido ☐ ☐ Poor appetite ☐ ☐ Fatigue ☐ ☐ Sudden weight gain/loss (circle one) ☐ ☐ Weakness Initials _____

Patient name _____

☐ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
☐	☐	AIDS	☐	☐	Tuberculosis
☐	☐	Alcoholism	☐	☐	Typhoid fever
☐	☐	Allergies	☐	☐	Ulcer
☐	☐	Arteriosclerosis	☐	☐	Other: _____
☐	☐	Cancer			_____
☐	☐	Chicken pox			_____
☐	☐	Diabetes			_____
☐	☐	Epilepsy			_____
☐	☐	Glaucoma			_____
☐	☐	Goiter			_____
☐	☐	Gout			_____
☐	☐	Heart disease			_____
☐	☐	Hepatitis			_____
☐	☐	HIV Positive			_____
☐	☐	Malaria			_____
☐	☐	Measles			_____
☐	☐	Multiple Sclerosis			_____
☐	☐	Mumps			_____
☐	☐	Polio			_____
☐	☐	Rheumatic fever			_____
☐	☐	Scarlet fever			_____
☐	☐	Sexually transmitted disease			_____
☐	☐	Stroke			_____

17. Injuries

Have you ever...

☐ Had a fractured or broken bone	☐ Used a crutch or other support
☐ Had a spine or nerve disorder	☐ Used neck or back bracing
☐ Been knocked unconscious	☐ Received a tattoo
☐ Been injured in an accident	☐ Had a body piercing

15. Operations

Surgical interventions, which may or may not have included hospitalization.

☐ Appendix removal
☐ Bypass surgery
☐ Cancer
☐ Cosmetic surgery
☐ Elective surgery: _____
☐ Eye surgery
☐ Hysterectomy
☐ Pacemaker
☐ Spine _____
☐ Tonsillectomy
☐ Vasectomy
☐ Other: _____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently
☐	☐ Acupuncture
☐	☐ Antibiotics
☐	☐ Birth control pills
☐	☐ Blood transfusions
☐	☐ Chemotherapy
☐	☐ Chiropractic care
☐	☐ Dialysis
☐	☐ Herbs
☐	☐ Homeopathy
☐	☐ Hormone replacement
☐	☐ Inhaler
☐	☐ Massage therapy
☐	☐ Physical therapy
☐	☐ Nutritional supplements:

List: _____

☐ Medications (prescription and over-the-counter):

Consultation Notes

18. Family History

Some health issues are hereditary. Tell Dr. Swickard about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	_____	☐	☐	_____	_____	☐	☐
Father	_____	☐	☐	_____	_____	☐	☐
Sister 1	_____	☐	☐	_____	_____	☐	☐
Sister 2	_____	☐	☐	_____	_____	☐	☐
Brother 1	_____	☐	☐	_____	_____	☐	☐
Brother 2	_____	☐	☐	_____	_____	☐	☐

19. Are there any other hereditary health issues that you know about?

20. Social History

Tell Dr. Swickard about your health habits and stress levels.

Alcohol use	☐ Daily ☐ Weekly	How much? _____
Coffee use	☐ Daily ☐ Weekly	How much? _____
Tobacco use	☐ Daily ☐ Weekly	How much? _____
Exercising	☐ Daily ☐ Weekly	How much? _____
Pain relievers	☐ Daily ☐ Weekly	How much? _____
Soft drinks	☐ Daily ☐ Weekly	How much? _____
Water intake	☐ Daily ☐ Weekly	How much? _____
Hobbies:	_____	

Prayer or meditation?	☐ Yes ☐ No
Job pressure/stress?	☐ Yes ☐ No
Financial peace?	☐ Yes ☐ No
Vaccinated?	☐ Yes ☐ No
Mercury fillings?	☐ Yes ☐ No
Recreational drugs?	☐ Yes ☐ No

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PAGE
3/4

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21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying down	☐	☐	☐	☐
Bending over	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	☐	☐	☐	☐
Household chores	☐	☐	☐	☐
Lifting objects	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Showering or bathing	☐	☐	☐	☐
Dressing myself	☐	☐	☐	☐
Love life	☐	☐	☐	☐
Getting to sleep	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Yard work	☐	☐	☐	☐

Patient name _____

22. What is the major stressor in your life? _____ 23. How much sleep do you average per night? _____ Hours

24. What is the type and approximate age of your mattress and pillow? _____ 25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: ☐ Skip breakfast ☐ Two meals a day ☐ Three meals a day ☐ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____	I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.
Initials _____	I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.
Initials _____	I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____
Initials _____	I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
Initials _____	I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.
Initials _____	To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

Signature _____

Date (MM/DD/YYYY) _____

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PAGE
4/4

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Notice of Privacy Practices Acknowledgement
Initial Uses Authorization Form
Swickard Chiropractic Clinic Chartered

Effective: April 14, 2003
Updated: September 23, 2013

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Swickard Chiropractic Clinic Chartered. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Denise M. Swickard.

Swickard Chiropractic Clinic Chartered also uses protected health information for the following reasons: (you may opt out of this authorization). Special initial authorization is required and attached. Marketing; internal referral board, testimonials, pictures on bulletin board, or information unrelated to healthcare and other marketing materials.
_____ (please initial if approve)

If you have any questions regarding this notice or our health information privacy policies, please contact: Denise M. Swickard at: Swickard Chiropractic Clinic Chartered, 15050 Antioch Road, Overland Park, Kansas, 913-205-6337
Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Your Email address: _____ (you may receive PHI through email)

Print Patient Name: _____

Signature Patient/Personal Representative: _____

Relationship of Personal Representative: _____

Date of Signature: _____

=====

Staff complete only if NO signature is obtained, If it is not possible to obtain the patient's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why the acknowledgement was not obtained.

- ☐ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices
- ☐ Other: _____

Staff Signature: _____ date: _____

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name: _____ Last Name: _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History (Record one diagnosis in your family history and the affected)				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		X		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Include regularly used over the counter medications)	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

For office use only			
Height: _____	Weight: _____	Blood Pressure: _____ / _____	
Swickard Chiropractic Clinic Chartered			