

UPDATED CONTACT INFORMATION

Please fill in your name and other demographic information that may need to be changed or updated in our files.

Today's Date (MM/DD/YYYY)

Gender

☐ Male ☐ Female

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

I certify that any changes to my personal information have been updated above for your records.

Signature

UPDATED CONTACT INFORMATION

UPDATED PATIENT HISTORY

Today's Date (MM/DD/YYYY) _____

Your Last Name _____

Your First Name _____

Your Middle Name (or Initial) _____

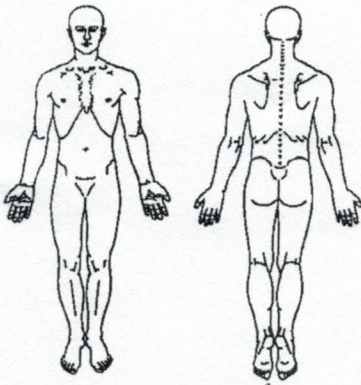
☐ I have new contact information

Please select one:

- ☐ **Progress evaluation** – I've been under active care and this is a periodic reevaluation.
☐ **New condition** – I've been under care and a new or returning condition has emerged.
☐ **Maintenance patient** – I'm under maintenance care with a new or returning health issue.
☐ **Returning patient** – After a period of inactivity, I've had a relapse or an all-new health issue.

Current symptoms: _____

1. Location (Where does it hurt?)
 Circle the area (s) on the illustration.



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

- ☐ Numbness
☐ Tingling
☐ Stiffness
☐ Dull
☐ Aching
☐ Cramps
☐ Nagging
☐ Sharp
☐ Burning
☐ Shooting
☐ Throbbing
☐ Stabbing
☐ Other _____

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

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

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

☐ Constant ☐ Come and goes.

When did it start and how often? _____

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

6. 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? _____

7. 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 _____

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

9. Review of systems (Identify any changes since your most recent evaluation with us):

- a. Musculoskeletal System** – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.
b. Neurological System – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.
c. Cardiovascular System – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.
d. Respiratory System – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.
e. Digestive System – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.
f. Sensory System – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.
g. Skin System – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.
h. Endocrine System – Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.
i. Genitourinary System – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.
j. Constitutional System – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.

Worse	No Change	Improved
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Illnesses, operations, injuries or treatments since your most recent evaluation with us: _____

This updated patient history is for:

- ☐ Current Patient
 Periodic Re-evaluation
☐ Current Patient
 Additional Complaint/
 Exacerbation
☐ Maintenance Patient (circle one)
 Exacerbation
 Re-Occurrence
 New Episode
☐ Inactive Patient (circle one)
 Exacerbation
 Re-Occurrence
 New Episode

Consultation Notes

UPDATED PATIENT HISTORY

Doctor's Initials _____

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11. Social History (Tell the 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

Patient name _____

12. 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. Is there anything else Dr. Swickard should know about your current condition, your progress or ways your current condition is affecting your life?

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: _____

Consultation Notes

Signature _____

Date (MM/DD/YYYY) _____

Doctor's Initials _____

Swickard Chiropractic Clinic Chtd

Dr. Bruce Swickard

Dr. Nicholas Swickard

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Swickard Chiropractic Clinic, Chartered
15050 Antioch Rd. Ste. 102
Overland Park, KS 66221

Bruce E. Swickard, DC
Nicholas J. Swickard, DC

Office Financial Policy

1. As a service to you we verify how your insurance company supports your care in our office. If we are unable to verify prior to the end of your first visit our policy is to collect \$65. Once benefits are known any credit will be refunded to you or used for future visits if you wish. Any balance will be due at your next visit.
2. We will collect your deductible, co-pay, uncovered services, and/or the percent you are responsible for at the time of each visit.
3. We will submit claims to your insurance and collect according to how they support your care. In the event insurance denies care (examples: services are not a covered benefit, insurance determines care is not medically necessary, etc.) you become responsible for the balance. You will become a "cash-pay" patient and will be responsible for the fees. Our cash-pay fee for spinal manipulations is \$50. Other treatments and services have additional fees.
4. CASH-PAY Patients: This includes patients who do not participate in insurance companies, patients who have insurance plan with which we do not participate or patients that have exhausted their benefits.
5. All effort is made by our billing office to work closely with the insurance companies. Most of the time we are quoted the correct benefits, however, benefits are sometimes misquoted. If we are misquoted and a balance is due on your account, it becomes patient responsibility. It is highly recommended that you verify your benefits as well.
6. Personal injury, Workman's Compensation, and Auto cases. A signed lien will be required allowing payments to be made directly to us. We will file on your behalf. Should benefits be exhausted or denied any unpaid balance becomes patient responsibility.

Patient or Guardian

Date

Printed Name