PREMIER CHIROPRACTIC & WELLNESS

324 C Southwind Place
Manhattan, KS 66503
(785) 320-5300

Patient Information

Welcome! Please allow our staff to photocopy your driver's license and all available insurance cards. PLEASE PRINT.

Name:_____ Nickname: _____ Social Security #_____

Address:_____ City:_____ State:_____ Zip:_____

E-mail address: _____ Home/Cell Phone:_____

Age:_____ Birth Date:_____ Occupation:_____

Employer:_____ Office Phone:_____

Employer's Address:_____ Spouse:_____

Spouse Occupation:_____ Spouse Employer:_____

How many children? _____ Names and Ages of Children:_____

Emergency Contact: _____ Emergency Contact Relationship: _____ Phone:_____

How were you referred to our office?

☐ Google ☐ Facebook ☐ Physician ☐ Insurance ☐ Referred by:_____ ☐ Other_____

Primary Care Provider and office: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐ Yes ☐ No

Please check all insurance coverage that may be applicable in this case**:**

☐ Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare ☐ Auto Accident ☐ Other_____

Name of Primary Insurance Company: _____
Name of Secondary Insurance Company (if any): _____
Primary Cardholder: _____Date of Birth of Primary Cardholder: _____
Address of Primary Cardholder (If different than above): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. <u>The following person(s) have my permission to receive my personal health information:</u>

_____

_____

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

OFFICE USE ONLY: Height: _____ Weight: _____ Blood Pressure:_____

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HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: _____

Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: ☐ Auto ☐ Work ☐ Other_____

Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents, or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? ☐ Yes ☐ No

If yes, describe:_____

Do you have any allergies of any kind? ☐ Yes ☐ No

If yes, describe:_____

Do you have a congenital condition? ☐ Yes ☐ No If YES, Describe _____

Women: Are you pregnant?_____ First day of last menstrual period? _____

Have you ever received chiropractic care? ☐ Yes ☐ No

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

Vigorous Exercise		Family Pressures	
Moderate Exercise		Financial Pressures	
Alcohol Use		Mental Stresses	
Drug Use		Other_____	
Caffeine Use		Other_____	
High Stress Activity			

PATIENT NAME _____ Date of Birth_____

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Indicate the current **intensity** of your complaint:

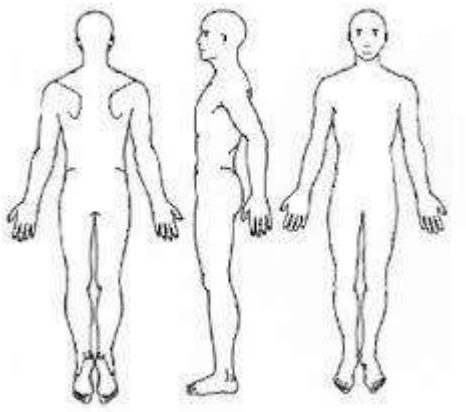
Mild									Severe
1	2	3	4	5	6	7	8	9	10

Indicate the **percentage** of daytime it is present:

Mild									Severe
10	20	30	40	50	60	70	80	90	100

How **long** have you been experiencing your main complaint? _____

Has the intensity **ever** been at a level of 9 or 10? ☐ Yes ☐ No
Using the letters below, please show where you are experiencing all of your current complaints:
A=Ache **B**=Burning **ST**=Stabbing **C**=Cramping **N**=Numbness **P**=Pins and Needles **T**=Throbbing



What makes it feel **better**? _____
What makes it feel **worse**?_____

Does this affect your work or other activities (check ALL that apply):
- ☐ Decision making
- ☐ Decreased productivity
- ☐ Exhausted at the end of day
- ☐ Unable to work
- ☐ Poor attitude
- Other: _____

Does this affect your life?
- ☐ Lose patience with spouse or children
- ☐ Restricted household duties
- ☐ Hinders ability to exercise/play sports
- ☐ Hinders ability to participate in hobbies/recreation.

Does your condition limit your ability to **DRIVE**?
☐ Unable to drive due to pain ☐ Able to drive 60 minutes ☐ 30 minutes ☐ 10 minutes ☐ No limitation

Does your condition limit your ability to **CARRY** objects?
☐ Unable to carry any weight ☐ Can carry heavy objects ☐ Moderate objects ☐ Light objects ☐ No limitation

Does your condition limit your ability to **SLEEP**?
☐ Unable to sleep ☐ Loss of 3-5 hour ☐ Loss of 2-3 hours ☐ Loss of 1-2 hours ☐ No limitation

Does your condition limit your ability to **STAND**?
☐ Unable to stand ☐ Able for <10 minutes ☐ 15 minutes ☐ 30 minutes ☐ 60 minutes ☐ No limitation

Does your condition limit your ability to **SIT**?
☐ Unable to sit ☐ Able for 1 hour ☐ Able for 2 hours ☐ Able for 4 hours ☐ Able for 8 hours ☐ No limitation

Does your condition limit your ability to go from **SITTING TO STANDING**?
☐ Unable without help ☐ Able from high chair ☐ Recliner ☐ Medium chair ☐ Low chair ☐ No limitation

Does your condition limit your ability to **WALK**?
☐ Unable to walk ☐ No more than 10 feet ☐ 1000 feet ☐ ½ mile ☐ 1 mile ☐ No limitation

Does your condition limit your ability to perform **HOUSEWORK**?
☐ Unable to do housework ☐ Able to do <10 minutes ☐ 15 minutes ☐ 30 minutes ☐ 60minutes ☐ No limitation

Does your condition limit your ability to **BEND**?
☐ Unable to bend ☐ Can bend ¼ of the way ☐ Can bend halfway ☐ Can bend ¾ of the way ☐ No limitation

I acknowledge that the above information is true and accurate to the best of my knowledge.
Patient Signature: _____ Date: _____
PATIENT NAME _____ Date of Birth_____

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Do you have any of the following?

Constitutional: fever, chills, night sweats, loss of appetite, unexplained weight loss/gain ☐ Yes ☐ No
Office Use: _____

Eyes/Vision: cataracts blindness, double vision, light sensitivity, blind spots, tearing, or burning ☐ Yes ☐ No
Office Use: _____

Ears, Nose & Throat: fainting, history of head injury, runny nose, dizziness, frequent sore throats, loss of smell or hearing, chronic sinus infections, ear discharge or pain, nosebleeds ☐ Yes ☐ No
Office Use: _____

Respiration: cough, shortness of breath, wheezing, asthma, coughing up blood or sputum ☐ Yes ☐ No
Office Use: _____

Cardiovascular: high or low blood pressure, pacemaker, shortness of breath, chest pain ☐ Yes ☐ No
Office Use: _____

Gastrointestinal: difficulty swallowing, abdominal pain, black/tarry stools, heartburn, ulcers, constipation, diarrhea, hemorrhoids, gallbladder issues ☐ Yes ☐ No
Office Use: _____

Females: Frequent urination, abnormal discharge, breast lumps or pain, abnormal cramping menstrual difficulties ☐ Yes ☐ No
Office Use: _____

Males: Burning or frequent urination, prostate issues, ED, urine retention ☐ Yes ☐ No
Office Use: _____

Musculoskeletal: Arthritis, rheumatoid arthritis, joint pain/swelling, numbness in arms/legs, weakness in extremities, muscle spasms, osteoarthritis ☐ Yes ☐ No
Office Use: _____

Neurological: headaches, migraines, dizziness, ears ringing, loss of balance ☐ Yes ☐ No
Office Use: _____

Psychological: anxiety, depression, irritability, nervousness, loss of memory ☐ Yes ☐ No
Office Use: _____

Other: stroke, diabetes, cancer, osteoporosis ☐ Yes ☐ No
Office Use: _____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Mark the appropriate box to indicate a family history.

M=Mother, F=Father, S=Sibling, G=Grandparent

Cancer, type _____	**Depression**	**Diabetes**	**Back Problems**
M F S G	M F S G	M F S G	M F S G

Heart Disease	**Liver Disease**	**High Blood Pressure**	**High Cholesterol**
M F S G	M F S G	M F S G	M F S G

Lung Problems	**Scoliosis**	**Neck Problems**	**Osteoporosis**
M F S G	M F S G	M F S G	M F S G

Seizures	**Osteoarthritis**	**Rheumatoid Arthritis**
M F S G	M F S G	M F S G

If any of the above family members are deceased, please list their age at death and cause:

_____

I acknowledge that the above information is true and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

Doctor Signature: _____ Date: _____

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Informed Consent Chiropractic Care

In coming to Premier Chiropractic & Wellness, you give the doctor permission and authority to care for you, the patient, in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. Premier Chiropractic & Wellness, of course, will not give any treatment or health care if they are aware that such care may be contra-indicated.

Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the doctor. Premier Chiropractic & Wellness provides specialized, non-duplicating health care service. Our doctors are licensed in chiropractic and are available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient at Premier Chiropractic & Wellness, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Initial _____

Photo/Announcement Release:

I, Patient Name (please print) _____, give Premier Chiropractic & Wellness permission to use my name and picture in its patient newsletter and on any office bulletin or other notice boards for purposes of announcing births, birthdays, weddings, graduations or acknowledging my referrals.

Initial _____

Email/Text Appointment Reminders

We try to utilize the most advanced and convenient way to remind you of your appointments. We offer email or text reminders with 24 hour prior notice. Please provide us with your cell phone and carrier to provide text alerts or email address to provide email alerts, or both. You may also opt out of this service by checking below.

Cell Phone Number: _____

Email Address: _____ Opt out here: ____

Patient Name:_____ Date of Birth: _____

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Please Read: This questionnaire is designed to enable us to understand how much your ***NECK PAIN*** has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you.

SECTION1--Pain Intensity A. I have no pain at the moment B. The pain is mild at the moment. C. The pain comes and goes and is moderate. D. The pain is moderate and does not vary much. E. The pain is severe but comes and goes. F. The pain is severe and does not vary much.	**SECTION 6 -- Concentration** A. I can concentrate fully when I want to with no difficulty. B. I can concentrate fully when I want to with slight difficulty. C. I have a fair degree of difficulty in concentrating when I want to. D. I have a lot of difficulty in concentrating when I want to. E. I have a great deal of difficulty in concentrating when I want to. F. I cannot concentrate at all.
SECTION 2--Personal Care (Washing, Dressing etc.) A. I can look after myself without causing extra pain. B. I can look after myself normally but it causes extra pain. C. It is painful to look after myself and I am slow and careful. D. I need some help, but manage most of my personal care. E. I need help every day in most aspects of self-care. F. I do not get dressed; I wash with difficulty and stay in bed.	**SECTION 7--Work** A. I can do as much work as I want to. B. I can only do my usual work, but no more. C. I can do most of my usual work, but no more. D. I cannot do my usual work. E. I can hardly do any work at all. F. I cannot do any work at all.
SECTION 3--Lifting A. I can lift heavy weights without extra pain. B. I can lift heavy weights, but it causes extra pain. C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table. D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. E. I can lift very light weights. F. I cannot lift or carry anything at all.	**SECTION 8--Driving** A. I can drive my car without neck pain. B. I can drive my car as long as I want with slight pain in my neck. C. I can drive my car as long as I want with moderate pain in my neck. D. I cannot drive my car as long as I want because of moderate pain in my neck. E. I can hardly drive my car at all because of severe pain in my neck. F. I cannot drive my car at all.
SECTION 4 --Reading A. I can read as much as I want to with no pain in my neck. B. I can read as much as I want with slight pain in my neck. C. I can read as much as I want with moderate pain in my neck. D. I cannot read as much as I want because of moderate pain in my neck. E. I cannot read as much as I want because of severe pain in my neck. F. I cannot read at all.	**SECTION 9--Sleeping** A. I have no trouble sleeping B. My sleep is slightly disturbed (less than 1 hour sleepless). C. My sleep is mildly disturbed (1-2 hours sleepless). D. My sleep is moderately disturbed (2-3 hours sleepless). E. My sleep is greatly disturbed (3-5 hours sleepless). F. My sleep is completely disturbed (5-7 hours sleepless).
SECTION 5--Headache A. I have no headaches at all. B. I have slight headaches which come infrequently. C. I have moderate headaches which come infrequently. D. I have moderate headaches which come frequently. E. I have severe headaches which come frequently. F. I have headaches almost all the time.	**SECTION 10--Recreation** A. I am able engage in all recreational activities with no pain in my neck at all. B. I am able engage in all recreational activities with some pain in my neck. C. I am able engage in most, but not all recreational activities because of pain in my neck. D. I am able engage in a few of my usual recreational activities because of pain in my neck. E. I can hardly do any recreational activities because of pain in my neck. F. I cannot do any recreational activities all..

SIGNATURE: _____DATE: _____

PATIENT NAME:_____DATE OF BIRTH:_____
DISABILITY INDEX SCORE (office use): %_____

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Please Read: This questionnaire is designed to enable us to understand how much your ***LOWER BACK*** has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you.

Section 1 – Pain Intensity

- □ I can tolerate the pain I have without having to use pain medication.
- □ The pain is bad but I manage without having to take pain medication.
- □ Pain medication provides me complete relief from pain.
- □ Pain medication provides me moderate relief from pain.
- □ Pain medication provides me little relief from pain.
- □ Pain medication has no effect on the pain

Section 2 – Personal Care (Washing, Dressing, etc.)

- □ I can take care of myself normally without causing increased pain.
- □ I can take care of myself normally but it increases my pain.
- □ It is painful to take care of myself and I am slow and careful.
- □ I need help but I am able to manage most of my personal care.
- □ I need help every day in most aspects of my care.
- □ I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting

- □ I can lift heavy weights without increased pain.
- □ I can lift heavy weights but it causes increased pain.
- □ Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. on a table.
- □ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- □ I can lift only very light weights.
- □ I cannot lift or carry anything at all.

Section 4 - Walking

- □ Pain does not prevent me walking any distance.
- □ Pain prevents me walking more than 1 mile.
- □ Pain prevents me walking more than ½ mile
- □ Pain prevents me walking more than ¼ mile
- □ I can only walk using crutches or a cane.
- □ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- □ I can it in any chair as long as I like.
- □ I can only sit in my favorite chair as long as I like.
- □ Pain prevents me sitting more than 1 hour.
- □ Pain prevents me from sitting more than ½ hour.
- □ Pain prevents me from sitting more than 10 mins.
- □ Pain prevents me from sitting at all.

Section 6 – Standing

- □ I can stand as long as I want without increased pain.
- □ I can stand as long as I want but it increases my pain.
- □ Pain prevents me from standing for more than 1 hour.
- □ Pain prevents me from standing for more than ½ hour.
- □ Pain prevents me from standing for more than 10 mins.
- □ Pain prevents me from standing at all.

Section 7 – Sleeping

- □ Pain does not prevent me from sleeping well.
- □ I can sleep well only by using pain medication.
- □ Even when I take pain medication, I sleep less than 6 hours.
- □ Even when I take pain medication, I sleep less than 4 hours.
- □ Even when I take pain medication, I sleep less than 2 hours.
- □ Pain prevents me from sleeping at all

Section 8 – Social Life

- □ My social life is normal and does not increase my pain.
- □ My social life is normal, but it increases my level of pain.
- □ Pain prevents me from participating in more energetic activities (ex sports, dancing, etc.).
- □ Pain prevents me from going out very often.
- □ Pain has restricted my social life to my home.
- □ I have hardly any social life because of my pain.

Section 9 – Traveling

- □ I can travel anywhere without increased pain.
- □ I can travel anywhere but it increases my pain.
- □ Pain restricts travel over 2 hours.
- □ Pain restricts travel over 1 hour.
- □ Pain restricts my travel to short, necessary journeys under ½ hour.
- □ Pain prevents all travel except for visits to the doctor/therapist or hospital.

Section 10 – Employment/Homemaking

- □ My normal homemaking/job activities do not cause pain.
- □ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- □ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. Lifting, vacuuming).
- □ Pain prevents me from doing anything but light duties.
- □ Pain prevents me from doing even light duties.
- □ Pain prevents me from performing any job/homemaking chores.

SIGNATURE:_____**DATE:**_____

PATIENT NAME:_____**DATE OF BIRTH:**_____

DISABILITY INDEX SCORE (office use): **%**_____