Pittsburg Chiropractic Center

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(620) 232-6555

Today's Date: _____/______/_____

PATIENT INFORMATION: **Name:** *(First, MI, Last)*____

Preferred Name: ______________________ **Phone:***(cell or home)* _____________________ **Work:** _________________

Date of Birth: _____/_____/_____ **Gender: MALE FEMALE** **Social Security#:**________________________

Address: ____________________________________ **City:** _______________________ **State:**_______ **Zip:**________

Preferred Method of Contact: PHONE TEXT MAIL EMAIL:____

Referred By: *(Name)* ________________________________ FAMILY FRIEND CO-WORKER DOCTOR OTHER

Marital Status: Single Married Divorced OTHER **Children:** ___________

Employed: NO YES (occupation)_____________________ **Student Status:** Full Time Student Part time Student

Height:_________________ **Weight:**_________________

Race & Ethnicity: ***(Choose up to 2)***

African American (or Black)
Hispanic or Latino
American Indian Alaskan Native
OTHER
Asian
White (Caucasian)

Preferred Language:

ENGLISH
SPANISH

EMERGENCY CONTACT INFORMATION:

Name: *(First, Last)* ________________________________ **Primary Care Physician:**________________________

Home Ph#: _____________________**Mobile:**_______________ **Doctor's Phone:**____________________________

Relationship: CHILD PARENT SPOUSE OTHER:_______________________________

FINANCIAL INFORMATION:

Is today's visit due to the result of an accident? NO AUTO WORK OTHER

Where would you like statements sent? SELF OTHER (Details Below)

Name:_______________________________ Address:____

Phone: ______________________________

Insurance Information:

Primary Insurance Holder Name: ____ DOB:______________

Primary Insurance Holder Address:____

ID#_______________________ Group#___________________ Primary Phone #:_______________________

Claims Address (usually on the back of the card)____

Financial Responsibility: SELF PARENT INSURANCE OTHER:________________________________

HISTORY OF PRESENT ILLNESS

When did it start? _____/_____/______ **What happened?** ____

____

Major Complaint:______________________________ **Secondary Complaints:**______________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

What are your daily activities being affected by your condition(s): ______________________________

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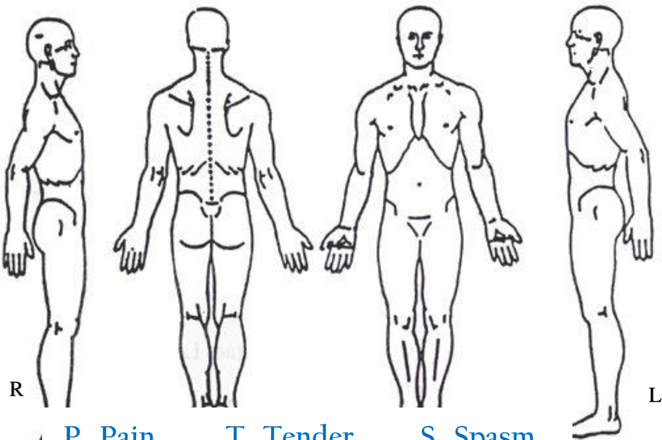
MAJOR COMPLAINT

Location of Symptoms and Radiation



P_ Pain T_ Tender S_ Spasm
N_ Numb TGL_ Tingling

Quality:

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy
- ☐ Dull
- ☐ Stiff & Sore
- ☐ Other:____________

Previous Treatment:

- ☐ None
- ☐ Chiropractor
- ☐ MD/DO
- ☐ Physical Therapy
- ☐ ER/Urgent Care
- ☐ Orthopedic
- ☐ Other:______________

Improves with? ______________________________

Ex: Ice, Heat, Movement, Stretching, OTC Medications, RX Medications

Does it Radiate? YES NO (Please indicate on drawing)

Grade Intensity/Severity:

None (0/10)

Mild (1-2 /10)

Mild-Moderate (2-4 /10)

Moderate (4-6 /10)

Moderate-Severe (7-10 /10)

Worsens with? ____

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(*Ex: Sitting, Standing, Walking, Lifting, Lying Down, Sleeping, Overuse, Work, Bending, etc.)*

Previous Diagnostic Tests? X-RAYS MRI CT NONE

****WOMEN: Are you pregnant? NO YES LMP:**__________

Pain Frequency: ALWAYS HOURLY DAILY OCCASIONALLY OFF & ON

Prescription Medications & Supplements: NONE YES (We can make a copy of your list of meds if you provide it to us)

If Yes (List- Name, dosage and frequency):___________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

PAST, FAMILY and SOCIAL HISTORY

PAST MEDICAL HISTORY

Have you ever had any of the following? (Please select all that apply and use comments to elaborate)

Illnesses:

- ○ Asthma
- ○ Autoimmune Disorder (Type) ______________________
- ○ Blood Clots
- ○ Cancer (Type)_____________
- ○ CVA/TIA (stroke)
- ○ Diabetes
- ○ Migraines
- ○ Osteoporosis
- ○ OTHER: _________________ ______________________ ______________________

Hospitalizations: (Non-surgical with Date)

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____

Surgeries: (If yes, provide type and date)

- ○ Cancer ___________________________
- ○ Orthopedic
  - Shoulder- R / L________________
  - Elbow/Forearm- R / L___________

Wrist/Hand- R / L _____________________

Hip- R /L ____________________________

Knee- R / L __________________________

Ankle/Foot- R / L _____________________

- ○ Spinal Surgery
  - Neck: _______________________
  - Back: _______________________
- ○ OTHER: _________________________

Medical History Comments:

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Injuries:

- ○ Back Injury
- ○ Broken Bones
- ○ Head/Neck Injury
- ○ Falls
- ○ MVA: ____

Family History: *(Please mark **X** to all that apply and use comments to elaborate* ☐ Unknown ☐ Unremarkable

	Mother	Father	Sibling 1	Sibling 2	Sibling 3	Child 1	Child 2	Child 3
Gender	**F**	**M**						
Age at Death								
Aneurysms								
CVA (stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

Family History Comments:

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SOCIAL & OCCUPATIONAL HISTORY

Caffeine Use: Coffee Tea Energy Drinks Soda NEVER

Smoking/Tobacco Use: Daily Some Days Former NEVER

Exercise Frequency: Daily 3-4xs/week 2-3xs week rarely NEVER

Alcohol Use: Daily Weekly Occasionally NEVER

REVIEW OF SYSTEMS

Many of the following conditions respond to Chiropractic and Acupuncture treatment

Are you currently experiencing any of these symptoms? (Please **Circle** all that apply and use comments to elaborate.)

Constitutional:
Fever
Fatigue

Musculoskeletal:
Joint Pain/Stiffness/Swelling
Muscle Pain/Stiffness/Spasms
Broken Bones_________________________
Other: _______________________________

Neurological:
Dizziness or Light headed
Convulsions or Seizures
Tremors
Other: _______________________________

Psychiatric:
Nervousness / Anxiety
Depression
Sleep Problems
Memory Loss / Confusion
Other: _______________________________

Genitourinary:
Frequent or Painful Urination
Blood in Urine
Incontinence or Bed Wetting
Painful or Irregular Periods
Other: _______________________________

Gastrointestinal:
Loss of Appetite
Blood in stool or Black stool
Nausea or Vomiting
Abdominal Pain
Frequent Diarrhea
Constipation
Other: ________________________

Cardiovascular & Heart:
Chest Pains/ Tightness
Rapid or Heartbeat Changes
Swelling of Hands, Ankles or Feet

Respiratory:
Difficulty Breathing
Cough

Eyes & Vision:
Eye Pain
Blurred or Double Vision
Sensitivity to Light
Other: _______________________________

Head, Ears, Nose, Mouth & Throat:
Frequent or Recurrent Headaches
Ear- Ache / Ringing / Drainage
Hearing Loss
Sensitivity to Loud Noises
Sinus Problems
Sore Throat
Other: _______________________________

Endocrine:
Infertility
Recent Weight Change
Eating Disorder
Other: _______________________________

Hematologic & Lymphatic:
Excessive Thirst or Urination
Cold Extremities
Swollen Glands
Other: _______________________________

Integumentary:
Rash or Itching
Change in Skin, Hair or Nails
Non-healing Sores or Lesions
Change of Appearance of a Mole
Breast Pain, Lump or Discharge
Other: ________________________

Allergic/Immunologic:
Food Allergies
Environmental Allergies
Other: ________________________

Review of Systems Comments:

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature____ Date: ____________

Print name: (First MI Last)____

Pittsburg Chiropractic Center

Jennifer M. Girth, DC

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to notify the privacy practices outlined in the Notice.

Requesting a Restriction on the User or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to use and disclosure of his or her Protected Health Information for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

☐ I,____ (print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my health information in accordance with it.

☐ I,____ (print) acknowledge that I have reviewed the above information and DO NOT give my permission to release any information to my insurance carrier. I do understand that Patient Health Information will be used within the office for purposes of my care to those individuals designated by the doctor.

ASSIGNMENT OF BENEFITS

At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 60 days from the date in which it was filed. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to contact your insurance carrier. **If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.**

Assignment and Conveyance of Lien Interest

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance policy to which I am entitled, and from which I am to paid in the form of an insurance settlement(s), claim(s), judgement(s), verdict(s) resulting from any identified accident. The Insurance Carrier is instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds the total dollar amount of all sums which I owe on account to the above named doctor and treating facility, as evidenced by the medical bills submitted by the doctor and/or treating facility, shall be paid directly to the above named doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled, or withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to the above named doctor and/or treating facility. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to such named doctor and treating facility and remit payment of all such sums directly to such name doctor and/or treating facility upon receipt of my settlement award(s).

INFORMED CONSENT TO TREATMENT

I hereby authorize and release the doctor and any individual she/he may designate as her/his assistant to administer treatment, physical examination, x-rays, chiropractic care or any clinical services that she/he deems necessary in my case. I understand that, as with any health care procedure complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare."

I, the undersigned parent or legal guardian of ______________________________(minor child), hereby give my permission to the staff of Pittsburg Chiropractic Center to treat said child. I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, she/he has complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I understand that failure to complete my recommended treatment plan my jeopardize my case.

Patient Signature:____ Date:______________________________

Patient Name (Print):____

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:__________________________________ **Last Name:**____

Email Address:____

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

DOB: ___/____/____ **Sex at Birth:** Male Female Unknown

Preferred Language: ________________________________

Sexual Orientation: Choose not to disclose / Lesbian, gay or homosexual / straight or heterosexual / bisexual / Don't Know / something else:________________________________

Gender Identity: Male / Female / Female-to-male (FTM/Transgender Male/Trans Man) / Male-to-Female (MTF Transgender Female / Trans Woman)

Smoking Status: Every day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle One): American Indian or Alaskan Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / Decline to Answer

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

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any allergies to medications? (Please list the medication name and reaction)

____

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

Patient Signature:____ **Date**:______________________

For Office Use Only

Height: __________ Weight: _________ Blood Pressure: ______ / _______