Baker Chiropractic & Acupuncture, LLC
DOWNTOWN KANSAS CITY, MISSOURI

Adult Patient Intake

1100 Main St. Suite 1950 Kansas City, MO 64105
(816) 842-3603

CONFIDENTIAL PATIENT CASE HISTORY

Today's Date:_____

Name:_____ Nickname:_____

Date of Birth:_____ Gender: M___ F___ Other___

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

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Marital Status: S___ M___ P___ W___ D___ Sep___ Spouse/Partner's Name:_____

Employer:_____ Occupation:_____

Employer Address:_____ City:_____ State:_____ Zip:____

Email:_____

Whom may we think for referring you to our office:_____

In case of emergency who should we contact?

Name:_____ Relationship:_____

Phone Number:_____

REASON FOR SEEKING CHIROPRACTIC CARE

Please list below any complaint(s) that Baker Chiropractic & Acupuncture can address for you.

1._____ When was the onset of Symptom?_____

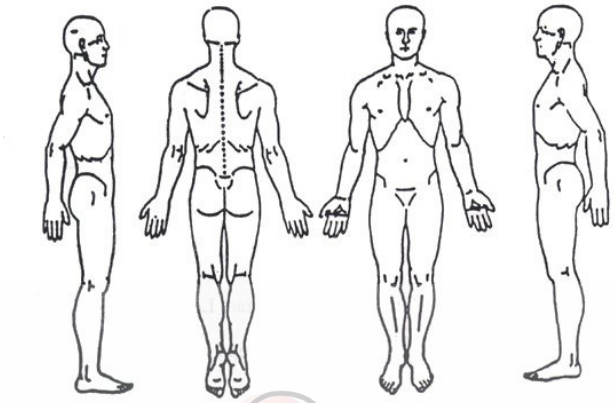
2._____ When was the onset of Symptom?_____

3._____ When was the onset of Symptom?_____

4._____ When was the onset of Symptom?_____

On the diagram, please circle the area(s) where you experience present complaints. Then, for each area that you have circled, designate a number from 1-10 (with 10 being the most pain) that corresponds to your CURRENT pain level.

	1-10	Burning	Dull	Sharp	Numb	Tingling	Ache	Other
Headache	___	Burning	Dull	Sharp	Numb	Tingling	Ache	Other
Neck	___	Burning	Dull	Sharp	Numb	Tingling	Ache	Other
Shoulder	___	Burning	Dull	Sharp	Numb	Tingling	Ache	Other
Mid Back	___	Burning	Dull	Sharp	Numb	Tingling	Ache	Other
Elbow	___	Burning	Dull	Sharp	Numb	Tingling	Ache	Other
Wrist	___	Burning	Dull	Sharp	Numb	Tingling	Ache	Other
Low Back	___	Burning	Dull	Sharp	Numb	Tingling	Ache	Other
Hip	___	Burning	Dull	Sharp	Numb	Tingling	Ache	Other
Knee	___	Burning	Dull	Sharp	Numb	Tingling	Ache	Other
Ankle	___	Burning	Dull	Sharp	Numb	Tingling	Ache	Other
Foot	___	Burning	Dull	Sharp	Numb	Tingling	Ache	Other
Other	___	Burning	Dull	Sharp	Numb	Tingling	Ache	Other



If other, please specify:_____

Has this condition: ___Gotten Worse ___Stayed Constant ___Occurred On and Off

Has this condition occurred before? ___Yes ___No

Please explain:_____

What activities aggravate your condition?_____

What makes your condition better?_____

Do you have any tingling, numbness or pain traveling to your arms, legs, hands or feet?_____

If yes, please describe:_____

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Does this interfere with (please check all that apply):

___Work/School ___Attention/Focus
___Exercise/Sports ___Communication
___Walking ___Eating
___Sleep ___Daily Routine

Please explain:_____

_____

If you have no symptoms or complaints, and are here for wellness services, please check here:___

HEATH CARE PRACTITIONER HISTORY

Have you seen other doctors for this condition? ___Yes ___No
Please list previous diagnoses you have received for your present condition:_____
Doctor's Name:_____
Type of Treatment:_____
Result of care:_____

Have you ever received chiropractic care? ___Yes ___No If yes, name of DC:_____
Reason:_____ How long?_____
Date of last visit:_____ Why was treatment stopped?_____

Have you consulted or do you regularly consult any of the following providers (please check all that apply):

___Medical Physician ___Naturopath ___Acupuncturist ___Homeopath
___Massage Therapist ___Psychotherapist ___Energy Healer ___Other:_____

Reason:_____

HEALTH HISTORY

Please check each of the diseases or conditions that you have now or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and course of care.

Family History: Check the following conditions that apply to you, or a member of your family

	You	Mother	Father	Grandparent	Explain
___Cancer	___	___	___	___	_____
___Diabetes	___	___	___	___	_____
___Heart Disease	___	___	___	___	_____
___HIV/AIDS	___	___	___	___	_____
___Multiple Sclerosis	___	___	___	___	_____
___Pace Maker	___	___	___	___	_____
___Autoimmune Disease (ie RA, SLE)	___	___	___	___	_____
___Stroke	___	___	___	___	_____

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List any surgeries you have had:

1._____ Date:_____ 2._____ Date:_____
3._____ Date:_____ 4._____ Date:_____

List any hospitalizations (besides surgeries) you have had:

1._____ Date:_____ 2._____ Date:_____
3._____ Date:_____ 4._____ Date:_____

Have you ever:

Broken a bone? ___Yes ___No Describe briefly:_____
Been knocked unconscious? ___Yes ___No Describe briefly:_____
Been treated for a spine/nerve disorder? ___Yes ___No Describe briefly:_____
Used a crutch, cane, or other support? ___Yes ___No Describe briefly:_____

List any traumas (even minor) including car accident, work, falls, injuries, etc. Please include approximate date.

_____
_____

P- Previous C- Current

General

P C Allergy/Hay Fever
P C Convulsions/Tremors
P C Dizziness
P C Depression/Anxiety
P C Fainting
P C Insomnia
P C Loss of Weight
P C Night Sweats

Muscle & Joint

P C Arthritis
P C Bursitis/Swollen Joints
P C Night Pain
P C Muscle Cramps at Night
P C Muscle Weakness
P C Scoliosis
P C Stiffness
P C Surgical Implant

Gastro-Intestional

P C Belching or Gas
P C Bloating after Meals
P C Constipation/Diarrhea
P C Gall Bladder Removed
P C Colitis

EENT

P C Deviated Septum
P C Frequent Colds/Ear Infections
P C Nosebleeds
P C Tinnitus (Ear Ringing)
P C Headaches

Endocrine

P C Afternoon Headaches
P C Crave Salt
P C Coarse or Thinning Hair
P C Get "Shaky" if Hungry
P C Inability to Concentrate
P C Increase in Weight
P C Sensitive to Cold
P C Hungry with No Weight Gain

Skin

P C Bruise Easily
P C Hives/Rash

Genito-Urinary

P C Excessive/Little Urination
P C Bladder Trouble
P C Painful Urination
P C Frequent Urination
P C Prostate Trouble

Cardio-Vascular

P C Asthma
P C Chest Pain
P C Chronic Cough
P C Difficulty Breathing/Wheezing
P C Hardening of Arteries
P C High/Low Blood Pressure
P C Pain over Heart/Chest
P C Spitting up Blood/Phlegm
P C Swelling of Ankles

For Women Only

P C Hot Flashes
P C Irregular/Painful/Excessive Menses
P C Painful Breasts
P C Premenstrual Tension

Are you pregnant? ___Yes ___No
How far along are you? ___ Weeks
Date of Last Menstrual Period? _____

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WELLNESS PROFILE

How much water do you drink per day on average?_____
How frequently do you eat per day? ___1-2 Meals ___3-4 Meals ___5-6 Meals ___Snack All Day
Do you drink soda? ___No ___Yes If yes: ___Diet ___Regular
How much caffeine do you have per day on average?_____
How frequently do you take over the counter medication?_____
What do you take?_____
How do you spend the majority of your day? ___Seated ___Standing ___Other:_____
How often do you use a Computer/TV per day on average? ___0-30 Min. ___30-60 Min. ___2 Hr. ___3 Hr. ___4+ Hr.
What type of shoes do you wear daily? ___Athletic ___Heels/Lifts ___Flats ___Dress
Do you use Arch Supports? ___Yes ___No
How well do you handle stress?_____
How much physical activity do you participate in on average per day?_____

Habits:					Comments:
Alcohol	Heavy	Moderate	Light	None	_____
Coffee	Heavy	Moderate	Light	None	_____
Tobacco	Heavy	Moderate	Light	None	_____
Drugs	Heavy	Moderate	Light	None	_____
Exercise	Heavy	Moderate	Light	None	_____
Appetite	Heavy	Moderate	Light	None	_____

Rate the following on a scale of 1-10 (10 being excellent):
Posture:___ Stress level:___ Daily Positive Thinking:___ Taking Time for Yourself:___ Doing Things You Love:___

How many hours of sleep do you get per night on average?_____
How would you rate your sleep on a scale of 1-10 (10 being excellent)?_____
What position do you sleep in?_____
How old is your mattress?_____
What type of mattress do you use?_____
Is your mattress comfortable?_____

MEDICATIONS

Please list all medications you currently take, INCLUDING dosage and frequencies:

_____
_____
_____

Do you now take vitamins, minerals, or herbs? ___No ___Yes If yes, list here:_____
Do you have an allergy to any medications? ___No ___Yes If yes, list here:_____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A signed consent form permits us to use your personal health information within our office for the purposes of treatment, receiving payment, and health care operations of our practice.

It is the policy of this practice to release only the minimum necessary information to any source not directly linked to hands on care and treatment of patients in our office as outlined in the Health Insurance Portability Accountability Act of 1996 (HIPAA). This includes third party payers, insurance companies, etc. In these cases your signed consent form permits us to release only enough information to complete the insurance claim process.

In some cases, patients may wish to have their protected health information released. In those cases if the outside entity can provide necessary information, or the amount of information requested by the patient.

In cases of public health, HIPAA does not protect some information. Where we are required by law to release information to any law enforcement or public health agency, our office will only release the minimum information required by law to any outside entity. In all cases we will follow the most restrictive laws, state or federal, that apply in protecting your medical information.

You, as a patient, have a right to see your medical record during normal office hours.

ADDITIONAL USES OF YOUR HEALTH INFORMATION

Our staff may use your health information to remind you of appointments, send birthday or seasonal greeting cards, mailings, newsletters, information about our practice or other information we feel you may be interested in or may improve your health. We will not release a mailing list to any outside entity for solicitation of business not related to our office.

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives us permission to use you Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations of our practice.

HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

You have the right to revoke, in writing, this consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent.

Patient Signature:_____ Date:_____

Restrictions:

You have my permission to share PHI with the following people:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our office's policies and practices may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised polices and practices will be applied to all protected health information we maintain.

Doctor/Staff Signature:_____ Date:_____

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Consent for Treatment

I understand that my outpatient registration, treatment or series of treatments by Baker Chiropractic & Acupuncture, LLC is necessary because of my condition. I voluntarily authorize and consent to the usual examination and treatments ordered by the Doctor and staff, including documentation and recording of history and examination.

Consent for Treatment of a Minor

I (We) being the parent, guardian, or custodians of _____, a minor, the age of _____, do hereby authorize, request and direct the Doctor/staff to preform in his/her judgement and necessary examinations, x-rays and recommended treatment for the condition.

Request for Records

I hereby authorize Baker Chiropractic & Acupuncture, LLC to request any medical records, x-rays, and specialized testing results, including serum and tissue testing results for the purpose of giving a better diagnostic picture. I permit a copy of this authorization to be used in requesting my records from any and all health care facilities, Physicians, and health care providers.

Payment & Insurance Release

I permit a copy of this authorization to be used in place of the original by Baker Chiropractic & Acupuncture, LLC. I authorize release to the Health Care Financing Administration and its agents any information needed to determine these benefits are payable.

I authorize any holder of medical information about me to be released to any of the above named health insurance or their contracted claims paying agents, and all information necessary to determine if these benefits are payable.

I authorize payments of medical benefits to this office.

When I pay by check, I expressly authorize this provider, if my check is dishonored or returned for any reason, to debit my account for the amount of the check plus a processing fee of $25.00 plus any applicable sales tax. The use of a check for payment is my acknowledgement and acceptance of this policy and its terms.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. However, I also understand and agree that all services rendered me are charged directly to me and services rendered me will be immediately due and payable. I further agree and understand this if the need arises, accounts delinquent by 90 days may be placed into legal collection agency. I understand and agree that I am responsible for all court cost, collection agency fees, filing fees and attorney fees that are incurred to collect my debt.

_____ _____

Date Patient Signature

_____ _____

Witnessed by: Parent/Guardian Signature - If Applicable

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Cancellation and No Show Policy

Your appointment time has been reserved specifically for you. We understand that situations arise that require you to cancel your appointment. In the event that you are unable to attend your scheduled appointment, we ask that you contact our office at least 24 hours in advance. This will allow us to offer this appointment to another patient who may need our services. With cancellations made less than 24 hours in advance, we are unable to offer that slot to other patients.

Office appointments that are canceled with less than 24 hours notice may result in the patient being required to pay in full for the missed appointment. Patients who do not come to their scheduled appointment without a call to cancel the appointment will be considered a No Show. Patients who No Show two (2) or more times in a 12 month period may be dismissed from the practice and denied any future appointments. Patients may also be required to pay in full for the No Show appointment.

We understand that circumstances may arise that are out of your control. Our office management will assess the situation and may waive the Cancellation Fee in certain circumstances.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before scheduling any future appointments for the patient.

In the event that you must cancel and cannot reach the office personnel, please leave a message on our voicemail system or email the office. Our answering machine will note the date and time of your call. No fee will be charged if your call or email is received within the above time frame.

By signing my name below, I acknowledge that I was provided with a copy of the Cancellation and No Show policy and that I have read and understand the Cancellation and No Show Policy and agree to its terms.

_____ _____

Patient Signature Date

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PHI & TPO Consent

I hereby give my consent for Baker Chiropractic and Acupuncture, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (The notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Baker Chiropractic & Acupuncture, LLC reserves the right to revise its Notice Of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Baker Chiropractic & Acupuncture, LLC, Privacy Officer, at 1100 Main Street Suite 1950, Kansas City, MO 64105.

With this consent, Baker Chiropractic & Acupuncture, LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders or any calls pertaining to my clinical care. However, our policy is not to leave detailed messages regarding Protected Health Information or anything related to treatment, payment, or healthcare operations.

With this consent, Baker Chiropractic & Acupuncture, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Baker Chiropractic & Acupuncture, LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Baker Chiropractic & Acupuncture, LLC restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my request restrictions, but it if does, it is bound by this agreement.

By signing this form, I am consenting to Baker Chiropractic & Acupuncture, LLC's use and disclosure of PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Baker Chiropractic & Acupuncture, LLC may decline to provide treatment.

I understand these policies and accept responsibility for payment of my account.

Responsible Party Signature:_____ Date:_____

Patient's Printed Name:_____