Name: _____ Date: _____

NEW INJURY / PATIENT UPDATE

Name: _____Date: _____

DOB: _____ SSN:_____ Marital Status: M S D W

Phone: (H) _____ (W) _____ (C) _____

Address: _____

City: _____ State: _____ Zip: _____ ___

Occupation: _____ Employer: _____

Emergency Contact Name:_____Emergency Contact Number:_____

☐ I authorize All Spine Chiropractic and wellness to leave or give information to my emergency contact.

Email Address: _____

☐ I authorize All Spine Chiropractic and Wellness. to send me emails for reminders and informational newsletters.

CHIEF COMPLAINT (CC)

Purpose of this visit: _____

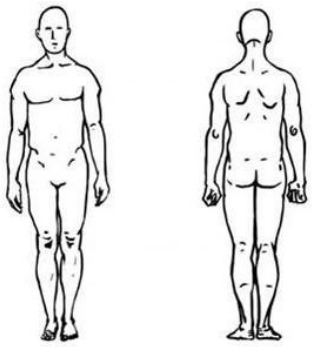
How/When Symptoms Appeared:

_____

_____

_____

Mark areas where you are experiencing pain with an "X."



Serious Illnesses since last visit: _____

Insurance Coverage: _____

Secondary Insurance Coverage (if applicable): _____

Any new information the doctor should know about your condition or your health in general?

_____

_____

All Spine Chiropractic and Wellness, LLC
125 N. Main St
Cheney, KS 67025
p: 316-542-3400 f: 316-542-3404

Name: _____ Date: _____

REVIEW OF SYSTEMS (ROS)

For new patients, established patients who may be having a new problem, or our patients who we have not seen in a while, we need to update our records as to your general health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed.

Constitutional Symptoms (Health in General) □ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer.
Other:_____

Eyes □ No Problems Blurred vision, crossed eyes, eye pain, discharge
Other:_____

Ears, Nose, Mouth & Throat □ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness.
Other:_____

Cardiovascular (Heart Related) □ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other:_____

Respiratory (Lungs & Breathing) □ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray.
Other:_____

Gastrointestinal (Stomach & Intestines) □ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence.
Other:_____

Genitourinary (Reproductive Organs & Urinary) □ No Problems Hematuria, excessive/reduced urination, kidney/bladder infections. Other:_____

Musculoskeletal (Muscles, Bones & Joints) □ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other:_____

Integumentary (Skin, Hair & Breast) □ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other:_____

Neurologic (Brain & Nerves) □ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss.
Other:_____

Psychiatric (Mood & Thinking) □ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other:_____

Endocrine (Glands) □ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other:_____

Hematologic/Lymphatic (Blood/Lymph) □ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other:_____

Allergic/Immunologic □ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other:_____

I have read the above information and certify it to be true and correct to the best of my knowledge.

Patient or Guardian Signature _____ Date_____

FOR OFFICE USE ONLY:
Practitioner:
Reviewed Date:

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HISTORY OF PRESENT ILLNESS (HPI)

Symptom 1 (Chief Complaint): _____

- Quality: Describe the quality of symptoms (circle all that apply):
  Sharp Dull Achy Burning Throbbing Piercing Stabbing
  Deep Nagging ShootingStinging Other:_____
- Severity: On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- Timing: What percentage of the time you are awake do you experience the above symptom at the above intensity:
  0 10 20 30 40 50 60 70 80 90 100
- Duration: When did the symptom begin? _____
- Context: How did the symptom begin? _____
- Did the symptom begin suddenly or gradually? (circle one)
- Modifying Factors: What makes the symptom better? (circle all that apply):
  Rest ice heat stretching exercise massage pain medication
  muscle relaxers nothing Other (please describe)_____
- What makes the symptom worse? (circle all that apply):

Sleeping	Turning in bed	Dressing	Walking	Sitting	Coughing
Laying on stomach	Exercise	Pulling	Bending forward	Standing	Exercise
Laying on side	Moving neck	Reaching	Bending backward	Laughing	Sit to stand
Laying on back	In/out of car	Stress	Computer use	Sneezing	Squatting

- Associated Signs & Symptoms: Does the symptom radiate to another part of your body (circle one):
  Yes No If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day Constant

Symptom 2 (Secondary Complaint): _____

- Quality: Describe the quality of symptoms (circle all that apply):
  Sharp Dull Achy Burning Throbbing Piercing Stabbing
  Deep Nagging ShootingStinging Other:_____
- Severity: On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- Timing: What percentage of the time you are awake do you experience the above symptom at the above intensity:
  0 10 20 30 40 50 60 70 80 90 100
- Duration: When did the symptom begin? _____
- Context: How did the symptom begin? _____
- Did the symptom begin suddenly or gradually? (circle one)
- Modifying Factors: What makes the symptom better? (circle all that apply):
  Rest ice heat stretching exercise massage pain medication
  muscle relaxers nothing Other (please describe)_____
- What makes the symptom worse? (circle all that apply):

Sleeping	Turning in bed	Dressing	Walking	Sitting	Coughing
Laying on stomach	Exercise	Pulling	Bending forward	Standing	Exercise
Laying on side	Moving neck	Reaching	Bending backward	Laughing	Sit to stand
Laying on back	In/out of car	Stress	Computer use	Sneezing	Squatting

- Associated Signs & Symptoms: Does the symptom radiate to another part of your body (circle one):
  Yes No If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day Constant

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INFORMED CONSENT FOR CHIROPRACTIC SPINAL MANIPULATION, DIAGNOSITC X-RAYS AND TREATMENT, AUTHORIZATION AND RELEASE

I hereby request and consent to the performance of chiropractic manipulation and other chiropractic procedures, including various modes of therapy modalities (including but not limited to ultrasound, muscle stimulation, interferential, ice, heat, traction, spinal decompression, Graston soft tissue, Kinesio/Rock Tape, therapeutic exercises, dry needling) and diagnostic x-rays, on myself (or on the patient named below for whom I am legally responsible) by or under the orders of the licensed doctors of chiropractic of the All Spine Chiropractic and Wellness (ASC&W), or any doctor, who now or in the future, works as a relief doctor. **Initials:_____** **Physician's Signature:_____**

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic manipulation and other procedures and understand that spinal manipulation involves the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications and realize that alternatives to care might include self-administered over the counter analgesics and rest, medical treatment; prescription drugs, such as anti-inflammatory, muscle relaxants and pain-killers, surgery or doing nothing. I understand the risks and dangers attendant to remaining untreated; over time this may complicate treatment making it more difficult and less effective the longer treatment is postponed. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest. **Initials:_____** **Physician's Signature:_____**

I authorize payment of insurance benefits directly to ASC&W, LLC, I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize the ASC&W, LLC to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand and agree 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. I understand the Federal Government has deemed it mandatory to notify my doctor of any other party or insurance company who may be responsible for reimbursement for my treatment.

Initials:_____

I have also read, or have had read to me the above informed consent, authorization and release. I have had an opportunity to ask any and all questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment in this office.

Patient Signature:_____Date____/_____/_____

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Name: _____ Date: _____

Printed Name:_____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES PURSUANT TO HIPAA AND CONSENT FOR USE OF HEALTH INFORMATION

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

By_____ on_____

Patient Signature Today's Date

If patient is a minor or under a guardianship order as defined by State law:

By_____

Signature of Parent/Guardian (Circle One)

FOR FEMALES ONLY

To the best of your knowledge, are you pregnant (or do you think you could be)?

Yes _____ No _____ Possibly _____

Patient Signature:_____Date_____

CONSENT TO TREATMENT OF A MINOR

I hereby authorize the doctors of ASC&W, LLC and/or whomever they designate as assistants, to administer treatment as deemed necessary to_____.

Signature of Parent or Legal Guardian:_____Date_____

Relationship:_____

Witness signature:_____Date_____

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