Miller Chiropractic Health Center

13470 Arapaho, Suite 150 Olathe, KS 66062 (913) 782-7260

PATIENT INFORMATION SHEET

PATIENT: **TODAY'S DATE:** ____________________

Last Name: ____________________ First Name: ____________________ Middle: __________

Gender: M F Date of Birth: ____/____/____ Age: ________ SS#: ____________________

Home Address: ____________________ Apt. #: ______ Marital Status: Single Married Other

City: ____________________ State: ______________ Zip: ____________

Home Phone #: ______________ Cell Phone #: ______________ Work Phone #: ______________

Employer Name: ____________________ Occupation: ____________________

Who referred you to our office? ____________________

E-mail address: ____________________

PRESENT COMPLAINT

What concerns/health complaints brought you here today?

What does this symptom(s) keep you from doing?

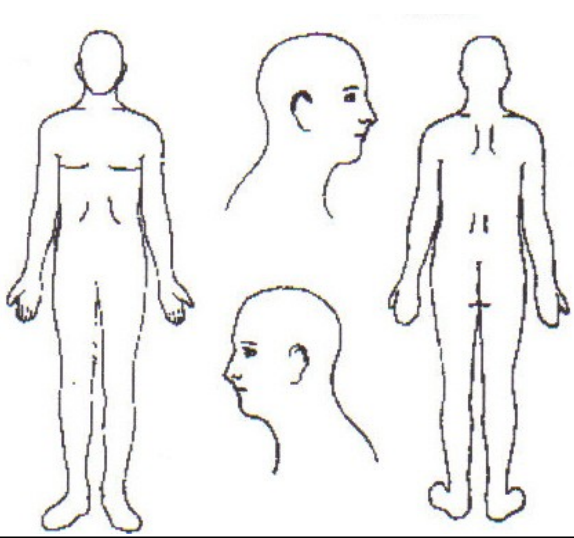
How long have you had this pain?

Is this your first episode?

Description of onset or injury:

Place an "X" on the drawing below on areas causing you pain and a letter describing it:

A = Ache
B = Burning
S = Stabbing
N = Numbness
P = Pins & Needles
R = Radiating
O = Other



PAIN SCALE

Please circle the number that best describes your pain:

0 1 2 3 4 5 6 7 8 9 10

None Little Medium Severe

Pain Frequency:	☐ Up to 1/4 of awake time	☐ 1/4 to 1/2 of time
	☐ 1/2 to 3/4 of awake time	☐ Most all the time
Pain Intensity:	☐ Doesn't affect	☐ Somewhat affects
	☐ Seriously affects	☐ Prevents activities

Actions affecting this pain:	Brings on	Aggravates	Relieves
☐ In the A.M.	☐	☐	☐
☐ In the P.M.	☐	☐	☐
☐ Bending forward	☐	☐	☐
☐ Bending back	☐	☐	☐
☐ Bending left	☐	☐	☐
☐ Bending right	☐	☐	☐
☐ Twisting left	☐	☐	☐
☐ Twisting right	☐	☐	☐
☐ Coughing	☐	☐	☐
☐ Sneezing	☐	☐	☐
☐ Straining	☐	☐	☐
☐ Standing	☐	☐	☐
☐ Sitting	☐	☐	☐
☐ Lifting	☐	☐	☐

SIGNATURE: (Patient, Parent, Legal Guardian or Responsible Party)

I request services X ____________________

PATIENT: **TODAY'S DATE:**

PATIENT INFORMATION SHEET (Continued)

EMERGENCY: Name and address of person to contact in case of an emergency

Last Name: ______________________ First Name: ______________ Middle: ______

Home Phone #: ____________ Cell Phone #: ____________ Work Phone #: ____________

Relationship to Patient: ____

SPOUSE/GUARDIAN/RESPONSIBLE PARTY:

Last Name: ____________________ First Name: ______________ Middle: ________

Employer Name: ____________________ Cell Phone #: ______________________

Date of Birth: ____/____/____ SS #: ____________ Work Phone # ____________________

NUTRITIONAL INFORMED CONSENT: Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Any suggested nutritional advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment. I have read and understand the above.

Signature: ________________________ **Date:** ________________________

PAYMENT IS DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.
PAYMENT METHOD: ☐ Cash ☐ Check ☐ Mastercard ☐ Visa ☐ Discover

INSURANCE: If you would like us to file a claim with your insurance, please give your insurance card to the receptionist so we may make a copy of it for our records. ALL CO-PAYS ARE DUE AT TIME OF SERVICE.

FINANCIAL/INSURANCE/COMMUNICATION POLICY: I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office will be credited to my account receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I give Miller Chiropractic Health Center and its representatives permission to communicate to me via the contact information above.

Patient's or authorized person's signature: ______________________**Date** ____________

I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

Patient's or authorized person's signature: ______________________ **Date** ____________

I authorize payment of medical benefits to the undersigned physician or supplier for services provided by this Office.

Insured's or authorized person's signature: ______________________ **Date** ____________

PATIENT PRIVACY ACT

I ACKNOWLEDGE THAT I HAVE RECEIVED, REVIEWED, AND UNDERSTAND AND AGREE TO THE *Notice of Privacy Practices* of Miller Chiropractic Office, PA, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice.

______________________________ ______________

Signature of patient or legal guardian Date

I give permission for the following persons to have full access to my medical records:

______________________________ ______________

Name Relationship

______________________________ ______________

Name Relationship

______________________________ ______________

Name Relationship

PATIENT: DOB: TODAY'S DATE:

HEALTH HISTORY

REVIEW OF SYSTEMS
Are you presently suffering (or within the past six months have suffered) from any of the following?

General:	☐ Normal ☐ Fatigue ☐ Weakness ☐ Fever ☐ Loss of sleep ☐ Chills ☐ Weight change ☐ Night sweats ☐ Other ________________
Skin:	☐ Normal ☐ Rash ☐ Redness ☐ Itching ☐ Dryness ☐ Eczema ☐ Hair changes ☐ Nail changes ☐ Bruise easily ☐ Other ________________
Neurological:	☐ Normal ☐ Headache ☐ Dizziness ☐ Fainting ☐ Convulsions ☐ Nervousness ☐ Other ________________
Eyes:	☐ Normal ☐ Vision trouble ☐ Pain ☐ Discharge ☐ Other ________________
Ears:	☐ Normal ☐ Hearing trouble ☐ Ringing ☐ Pain ☐ Discharge ☐ Other ________________
Nose:	☐ Normal ☐ Pain ☐ Bleeding ☐ Sinus Problems ☐ Infections ☐ Absence of smell ☐ Other ________________
Mouth/Throat:	☐ Normal ☐ Sores ☐ Bleeding ☐ Enlarged glands ☐ Absence of taste ☐ Abnormal taste ☐ Tonsillitis ☐ Other ________________
Cardio-Vascular-Pulmonary: (Heart/Lungs)	☐ Normal ☐ Cough ☐ Wheezing ☐ Difficulty breathing ☐ Swollen extremities ☐ Blue extremities ☐ Varicosities ☐ Murmur ☐ Chest Pain ☐ Palpitations ☐ Other ________________
Breasts:	☐ Normal ☐ Lumps in breast ☐ Redness/Itching ☐ Pain ☐ ☐ Dimpling ☐ Discharge ☐ Other ________________
Gastrointestinal: (Stomach/Digestion)	☐ Normal ☐ Decreased appetite ☐ Increased appetite ☐ Abdominal pain ☐ Hemorrhoids ☐ Excess gas ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Other ________________
Genitourinary:	☐ Normal ☐ Inability to hold urine ☐ Painful urination ☐ Frequent urination ☐ Bedwetting ☐ Irregular menstruation ☐ Painful menstruation ☐ Sterility ☐ Abnormal vaginal bleeding ☐ Impotence ☐ Prostate problems ☐ Other ________________
Endocrine: (Metabolism)	☐ Normal ☐ Heat/Cold intolerance ☐ Sugar in urine ☐ Goiter ☐ Tremor ☐ Other ________________
Psychological:	☐ Normal ☐ Anxiety ☐ Depression ☐ Memory loss or impairment ☐ Phobias ☐ Mood swings ☐ Other ________________

DOCTOR'S NOTES:

PATIENT:	TODAY'S DATE:

MEDICAL HISTORY

If you now have or you have had one of the following illnesses, please check EITHER "now have" or "have had".

Arthritis	□ Now have	□ Have had	Sexually transmitted disease	□ Now have	□ Have had
Asthma	□ Now have	□ Have had	Ulcer	□ Now have	□ Have had
Sinus trouble	□ Now have	□ Have had	Cancer	□ Now have	□ Have had
Hay fever	□ Now have	□ Have had	Polio	□ Now have	□ Have had
Allergies	□ Now have	□ Have had	Rheumatic fever	□ Now have	□ Have had
Tuberculosis	□ Now have	□ Have had	Serious injury	□ Now have	□ Have had
Diabetes	□ Now have	□ Have had	Bone fracture	□ Now have	□ Have had
Epilepsy	□ Now have	□ Have had	Dislocated joints	□ Now have	□ Have had
Thyroid trouble	□ Now have	□ Have had	Spinal disc disease	□ Now have	□ Have had
High blood pressure	□ Now have	□ Have had	Multiple sclerosis	□ Now have	□ Have had
Low blood pressure	□ Now have	□ Have had	Scoliosis	□ Now have	□ Have had
Heart trouble	□ Now have	□ Have had	Mental/Emotional difficulty	□ Now have	□ Have had
Pacemaker	□ Now have	□ Have had	Prostate trouble	□ Now have	□ Have had
HIV/ARC	□ Now have	□ Have had	Kidney trouble	□ Now have	□ Have had
AIDS	□ Now have	□ Have had	Other ____________________	□ Now have	□ Have had
Other _____________	□ Now have	□ Have had			

HEALTH CARE

Have you ever been to a chiropractor? □ Yes □ No

Do you have a family physician? □ Yes □ No Physician's name and address:

Do you wish to grant Miller Chiropractic Health Center physicians permission to share/discuss medical findings with your other healthcare providers (i.e. MD, DO Orthopedist, Surgeon, etc.) if they deem necessary? □ Yes □ No

Date of last physical examination:

Have you been hospitalized in the past? □ Yes □ No

Date and reason for hospitalization:

Have you had surgery in the past? □ Yes □ No

Date and reason for surgery:

Have you ever had a serious accident in the past? □ Yes □ v No

List date and describe injury:

Do you have any drug allergies? □ Yes □ No

List drugs you are allergic to:

Are you currently taking any medication? □ Yes □ No

If yes: h Anti-inflammatory (Aspirin, Motrin, etc.) □ Muscle relaxants □ Tranquilizers

□ Pain medication/analgesic □ Antibiotics

h Blood pressure pills h Birth control pills

h Other ____________________________

For what condition(s) are you taking medication?

WOMEN ONLY:

To your knowledge, are you pregnant? □ Yes □ No

Have your past pregnancies been normal? □ Yes □ No

Are you seeing an OB-GYN regularly? □ Yes □ No

Date of last exam:

Physician's name and address:

PATIENT:	TODAY'S DATE:

FAMILY HEALTH HISTORY

Has any blood relative had:	Who?					
Cancer	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Child	☐ Grandparent
Diabetes	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Child	☐ Grandparent
Heart trouble	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Child	☐ Grandparent
High blood pressure	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Child	☐ Grandparent
Stroke	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Child	☐ Grandparent
Multiple sclerosis	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Child	☐ Grandparent
Headaches	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Child	☐ Grandparent
Neck problems	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Child	☐ Grandparent
Back problems	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Child	☐ Grandparent
Disc problems	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Child	☐ Grandparent
Joint problems	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Child	☐ Grandparent
Arthritis	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Child	☐ Grandparent
Pinched nerve	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Child	☐ Grandparent
Osteoporosis	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Child	☐ Grandparent
Scoliosis	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Child	☐ Grandparent
Bad posture	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Child	☐ Grandparent

OCCUPATIONAL INFORMATION — ACTIVITIES OF DAILY LIVING

Job Type ☐ Full time ☐ Part time ☐ Temporary ☐ Other ________________

Work Week

Hours Per Day	☐ 1-2 hours	☐ 3-4 hours	☐ 5-6 hours	☐ 7-8 hours	☐ 9-10 hours	☐ 11-12 hours	
Days Per Week	☐ 1 day	☐ 2 days	☐ 3 days	☐ 4 days	☐ 5 days	☐ 6 days	☐ 7 days

Do your present complaints affect the number of hours you work per day ? ☐ Yes ☐ No

Length of Time at Present Occupation ☐ ____# of Years (fill in) ☐ ____# of Months (fill in)

Job Involves:

Lifting ☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ _____# of pounds

Additional Job Requirements ☐ Bending ☐ Stooping ☐ Twisting ☐ Turning ☐ Carrying ☐ Walking

Primary Work

Position ☐ Seated ☐ Standing ☐ Other (list) ________________

Location ☐ Desk ☐ Counter ☐ Workbench ☐ Other (list) ____________

Do you wear shoes or boots with high heels? ☐ Never ☐ Seldom ☐ Occasionally ☐ Frequently

Are you right-handed or left-handed? ☐ Right ☐ Left

Do work activities aggravate your present complaints? ☐ Yes ☐ No

Which of the following best describes your stress level? ☐ None ☐ Minimal ☐ Moderate ☐ Severe

How do you rate your physical activity at work? ☐ Seated more than 50% of workday ☐ Light manual labor ☐ Moderate manual labor ☐ Heavy manual labor

What hobbies do you participate in?

List hobbies:

1. ______________________ ☐ Occasionally ☐ Frequently ☐ Constantly
2. ______________________ ☐ Occasionally ☐ Frequently ☐ Constantly
3. ______________________ ☐ Occasionally ☐ Frequently ☐ Constantly

What are your habits?

Smoking	☐ Never	☐ Number of packs/day ___________
Alcohol	☐ Never	☐ Number of drinks/day ___________
Caffeinated drinks	☐ Never	☐ Number of cups/glasses/day ___________
Exercise	☐ Never	☐ Number of days a week ___________
Drug/Substance abuse	☐ Never	☐ Yes (discuss with doctor)

Functional Index Rating

Instructions

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your condition (neck/back pain) for which you are currently seeking care. Please provider an answer for each activity.

Today, do you or would you have any difficulty at all with:

	Activities	0	1	2	3	4
1.	**Pain Intensity**	No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
2.	**Sleeping**	Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
3.	**Personal Care (washing, dressing, etc.)**	No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance
4.	**Travel (driving, etc.)**	No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain; need 100% assistance
5.	**Work**	Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot Work
6.	**Recreation**	Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities
7.	**Frequency of pain**	No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day
8.	**Lifting**	No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
9.	**Walking**	No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking
10.	**Standing**	No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name: ______________________________ **DOB:** _______

Signature: ___________________________ **Score:** _____

Date: _______________________________ (office use only)