

Miller Chiropractic Health Center

13470 Arapaho, Suite 150

Olathe, KS 66062

(913) 782-7260

PATIENT INFORMATION SHEET—Minor Child

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 #: _____
 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?

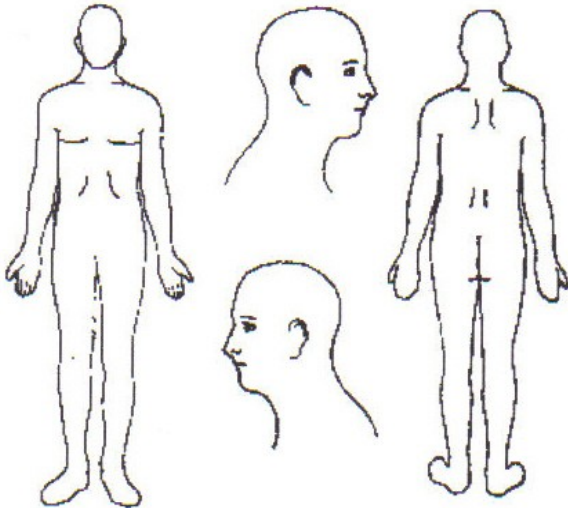
How long have you had this pain?

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
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

I request services _____

PATIENT: _____ DOB: _____ TODAY'S DATE: _____

PATIENT INFORMATION SHEET (Continued)

Authorization for Care of a Minor Child Under 18 Years of Age
I hereby authorize and consent to the chiropractic evaluation of my child,

Parent(s) _____ Contact Phone: _____

Parent/Guardian Signature: _____ Date: _____

RESPONSIBLE PARTY/SPOUSE or GUARDIAN: Complete this section if you are not the patient but are responsible for the bill.

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____ Apt. #: _____ Cell/Home Phone: _____

City: _____ State: _____ Zip: _____ Date of Birth: ____/____/____

PAYMENT IS DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. 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/Co-insurance 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** _____

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:** _____

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: _____ DOB: _____ 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	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had	Sexually transmitted disease	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had
Asthma	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had	Ulcer	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had
Sinus trouble	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had	Cancer	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had
Hay fever	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had	Polio	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had
Allergies	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had	Rheumatic fever	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had
Tuberculosis	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had	Serious injury	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had
Diabetes	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had	Bone fracture	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had
Epilepsy	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had	Dislocated joints	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had
Thyroid trouble	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had	Spinal disc disease	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had
High blood pressure	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had	Multiple sclerosis	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had
Low blood pressure	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had	Scoliosis	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had
Heart trouble	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had	Mental/Emotional difficulty	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had
Pacemaker	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had	Prostate trouble	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had
HIV/ARC	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had	Kidney trouble	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had
AIDS	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had	Other _____	<input type="checkbox"/> Now have	<input type="checkbox"/> Have had
Other _____	<input type="checkbox"/> Now have	<input type="checkbox"/> 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 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: Anti-inflammatory (Aspirin, Motrin, etc.) Muscle relaxants Tranquilizers
 Pain medication/analgesic Antibiotics

Blood pressure pills Birth control pills

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:

DOB:

TODAY'S DATE:

FAMILY HEALTH HISTORY

Has any blood relative had:

Who?

h Cancer	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Child	<input type="checkbox"/> Grandparent
h Diabetes	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Child	<input type="checkbox"/> Grandparent
h Heart trouble	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Child	<input type="checkbox"/> Grandparent
h High blood pressure	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Child	<input type="checkbox"/> Grandparent
h Stroke	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Child	<input type="checkbox"/> Grandparent
h Multiple sclerosis	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Child	<input type="checkbox"/> Grandparent
h Headaches	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Child	<input type="checkbox"/> Grandparent
h Neck problems	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Child	<input type="checkbox"/> Grandparent
h Back problems	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Child	<input type="checkbox"/> Grandparent
h Disc problems	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Child	<input type="checkbox"/> Grandparent
h Joint problems	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Child	<input type="checkbox"/> 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 provide 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)