# Miller Chiropractic Health Center

13470 S. 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: _____ Preferred language: _____

Home Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Primary Phone #: _____ Cell, Home, Work? Secondary Phone #: _____ Cell, Home, Work?

Preferred method of communication: Phone Text Email

E-mail address: _____

Occupation: _____ Employer Name: _____

Who may we thank for referring you to our office?_____

## PRESENT HEALTH COMPLAINTS/CONCERNS

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? ☐ Yes ☐ No If yes, please explain: _____

Description of onset or injury: _____

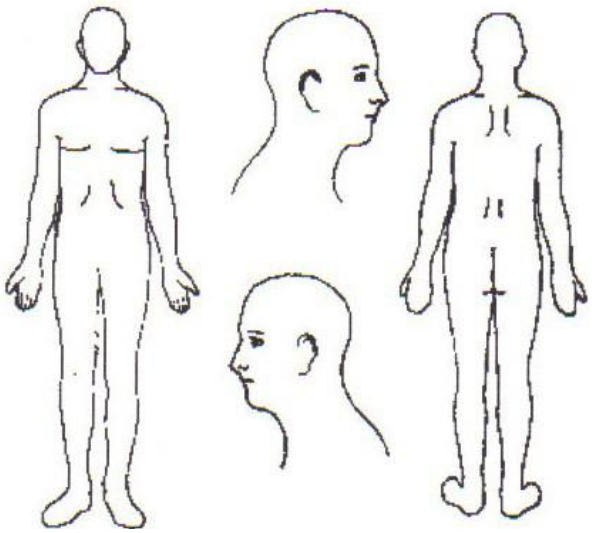
_____

_____

_____

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 ¼ of awake time<br>☐ up to ½ to ¾ of awake time | ☐ up to ¼ to ½ of awake time<br>☐ most all the time |
| Pain Intensity: | ☐ Doesn't affect<br>☐ Seriously affects | ☐ Somewhat affects<br>☐ 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 | ☐ | ☐ | ☐ |

Other health care professionals you have seen for this condition:

☐ "Limited Scope" Chiropractor (focuses mainly on neck and back pain)

☐ "Wellness Chiropractor" (focuses on health and wellbeing as well as underlying cause of pain and health concerns)

☐ Medical Doctor ☐ Dentist ☐ Other:

PATIENT NAME: DOB: DATE:

## HEALTH HISTORY

**REVIEW OF SYSTEMS:**

**Are you presently suffer 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 ☐ Acne ☐ 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: |
| **Cardiovascular-Pulmonary: (Heart/Lungs)** | ☐ Normal ☐ Cough ☐ Wheezing ☐ Difficulty breathing ☐ Swollen extremities ☐ Blue extremities ☐ Varicosities ☐ Chest pain ☐ Palpitations ☐ Murmur ☐ Other: |
| **Breasts:** | ☐ Normal ☐ Lumps in breast ☐ Redness/itching ☐ Pain ☐ Dimpling ☐ Discharge ☐ Other: |
| **Gastrointestinal: (Stomach/Digestion)** | ☐ Normal ☐ Decreased appetite ☐ Increased appetite ☐ Abdominal Pain ☐ Reflux ☐ 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 ☐ Prostate Problems ☐ Impotence ☐ 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:**

## HEALTH CARE

**Have you ever been to a chiropractor?** ☐ Yes ☐ No

**Primary Care Physician:** **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: _____

**Hospitalizations? Surgeries?** ☐ Yes ☐ No If yes, please list dates and reasons

PATIENT NAME: DOB: DATE:

**Serious Accidents or injuries: Please list dates and describe injuries:**

**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 Location _____

## MEDICAL HISTORY

**If you NOW HAVE or 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 | | ☐ Now have | ☐ Have had |
| Allergies | ☐ Now have | ☐ Have had | Polio | ☐ Now have | ☐ Have had |
| Tuberculosis | ☐ Now have | ☐ Have had | Rheumatic Fever | ☐ Now have | ☐ Have had |
| Diabetes | ☐ Now have | ☐ Have had | Serious Injury | ☐ Now have | ☐ Have had |
| Epilepsy | ☐ Now have | ☐ Have had | Bone fracture | ☐ Now have | ☐ Have had |
| Thyroid trouble | ☐ Now have | ☐ Have had | Dislocated joints | ☐ Now have | ☐ Have had |
| High Blood Pressure | ☐ Now have | ☐ Have had | Spinal disc disease | ☐ Now have | ☐ Have had |
| Low Blood Pressure | ☐ Now have | ☐ Have had | Multiple sclerosis | ☐ Now have | ☐ Have had |
| Heart Trouble | ☐ Now have | ☐ Have had | Scoliosis | ☐ Now have | ☐ Have had |
| Pacemaker | ☐ Now have | ☐ Have had | Mental/Emotional difficulty | ☐ Now have | ☐ Have had |
| HIV/AIDS | ☐ Now have | ☐ Have had | Prostate Trouble | ☐ Now have | ☐ Have had |
| Other _____ | ☐ Now have | ☐ Have had | Kidney Trouble | ☐ Now have | ☐ Have had |
| | | | Other _____ | | |

**STRESSORS:** Because accumulation of stress affects our health and ability to heal, please list your top three stressors **(you have ever had)** in each category:

**Please circle the number that best describes your CURRENT stress level:**

**0 1 2 3 4 5 6 7 8 9 10**

**None Little Medium Severe**

**PHYSICAL Stress:** (falls, accidents, work postures, sports etc)

1. _____
2. _____
3. _____

**BIO-CHEMICAL Stress:** (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc)

1. _____
2. _____
3. _____

**MENTAL/emotional or psychological stress:** (work, relationships, finances, self-esteem, trauma, etc)

1. _____
2. _____
3. _____

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

*CMS requires providers to report both race and ethnicity*

**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications? ___ Yes ___ No** (Please include regularly used over the counter medications) **Please list below or attach a current list.**

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

**Do you have any medication allergies?** ___ Yes ___ No **If yes, please list below.**

| Medication Name | Reaction | Onset Date | Additional Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

***For office use only***

Height: _____ Weight:_____ Blood Pressure:_____ /_____

PATIENT NAME: DOB: DATE:

## FAMILY HEALTH HISTORY

Has any blood relative had the following?

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 a 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 ☐_____# of Months

**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/boots with a heel over 1.5 inches? ☐ Yes ☐ No

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

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

What hobbies do you participate in?

| | | | |
|---|---|---|---|
| 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 per day _____ |
| Caffeinated drinks | ☐ Never | ☐ Number of cups/glasses per day _____ |
| Exercise | ☐ Never | ☐ Number of days a week _____ |
| Drug/Substance abuse | ☐ Never | ☐ Yes (discuss with doctor) _____ _____ |

PATIENT NAME: DOB: DATE:

Miller Chiropractic Health Center

# 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 |

**Patient Signature**: _____ **Score:** _____ **(** office use only)

PATIENT NAME: DOB: DATE:

## EMERGENCY CONTACT, AUTHORIZATIONS, CONSENTS

**CONSENT FOR TREATMENT:** I request services

**Patient's or authorized person's signature:** _____ **Date** _____

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

Last name: _____ First Name:_____ Middle:_____

Primary Phone #: _____ Cell, Home, Work? Secondary Phone #: _____ Cell, Home, Work?

Relationship to Patient: _____

**SPOUSE/GUARDIAN/RESPONSIBLE PARTY:**

Last name: _____ First Name:_____ Middle:_____

Relationship to Patient: _____Employer Name: _____

Primary Phone #: _____ Cell, Home, Work? Secondary Phone #: _____ Cell, Home, Work?

Date of Birth: _____/_____/ _____ SS #: _____

**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.

**Patient's or authorized person's 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 POLICY/ INSURANCE/ COMMUNICATION POLICY:** I clearly 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 collections 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 to 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 _____