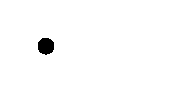
## Brookside Chiropractic LLC.

**601 E. 63rd Street, Suite 400, Kansas City, MO 64110** [**info@brookside-chiropractic.com**](mailto:info@balancedwellnessok.com)

#### INTRODUCTION PATIENT CASE HISTORY

**Today’s Date:**

#### PATIENT INFORMATION

**Name:** (Last, First MI) **Preferred Name**: **Address: City: State: Zip: Home: Mobile: Mobile Carrier: Work: Email: Gender:** M / F **Marital Status:** Married / Other / Single **Social Security #**: \_ **Date of Birth: Student Status:** Full Student / Part Student / Non-Student **Employed Employer:**

**\*Referred By:**

**Ethnicity**: Hispanic or Latino / Other **Preferred Language:**

**Race:** Asian / African Am. / Am. Indian or Alaskan Native / **Smoking Status**: Every Day / Some Days / Former / Never Other / Native Hawaii or Pacific Island / White

#### EMERGENCY CONTACT INFORMATION

**Full Name: Home: Mobile: Relationship**: Child / Parent / Spouse / Other:

**Primary Care Physician: Doctor’s Phone:**

**Who is responsible for payment?** Self / Other - *(Relationship)*

*Other than Self:*

**Full Name**: **Phone:**

**Address: City: State: Zip:**

***It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged***

**Patient No:** Page **1** of **6**

# PATIENT CASE HISTORY

#### HISTORY OF CURRENT CONDITION

**Describe Major Complaint: Began When?** / / **Describe how this began:**

**Grade Intensity/Severity of Complaint:** None / Mild / Moderate / Severe / Very Severe

**Quality of the complaint/pain**: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other:

**How frequent is the complaint present?** Off & On / Constant

**Does this complaint radiate/shoot to any areas of your body? No / Yes** *(Describe)*

*Head -* Base of Skull / Forehead / Sides-Temple R / L / Both

*Arm –* Across Shoulder / Elbow / Hand-Fingers R / L / Both

*Leg -* Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

*Other Area:*

**Does anything make the complaint better?** Ice / Heat / Rest / Movement / Stretching / OTC / Other: **Does anything make the complaint worse?** Sit / Stand / Walk / Lying / Sleep / Overuse / Other: **Which daily activities are being affected by thiscondition?** *(Describe)* **For this CURRENT condition, have you:**

* **Received any other treatment?** None / DC / MD / PT / Massage / ER/ Other: **Where?**
* **Had any previous Surgery or Interventions in this area?** *(Describe)*
* **Taken any Medications?** OTC / Prescriptions
* **Had any diagnostic testing?** X-rays / MRI / CT / Other: **When and Where? Describe any Secondary Complaints:**

**HEALTH HISTORY – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)***

***Medications:***

**Allergies to Medications: *NONE*** *(List)*

***Family Health History:***

**List *relevant* major health problems of immediaterelatives:**

**Current Medications: *NONE***

*(Already have a list? We can make a copy.)*

**Deaths in immediate family:** *(Cause and at what Age?)*

***Past Health History:*** *(Please list any past…)*

**Surgeries – Date, Type, and Reason: *NONE Social and Occupational History:***

**Level of Education Completed:**

High School / Some College / College Grad. / Post Grad. / Other

**Lifestyle:** *(Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)*

**Major Injuries/Traumas: *NONE***

**Major Hospitalizations: *NONE***

**Habits:**

Cigarettes – *(#/day)* Alcohol – *(amount/day)*

#### REVIEW OF SYSTEMS

**Are you *currently* experiencing any of these symptoms? *(Check all theapply)***

#### Many of the following conditions respond to Chiropractic and Acupuncturetreatment.

**General:** *(constitutional)* Recent Weight Change Fever



Fatigue

*None in this Category*

**Musculoskeletal:**

Low Back Pain Mid Back Pain Neck Pain



Arm Problems Leg Problems Painful Joints

Stiff/Swollen Joints Sore/Weak Muscles or Joints Muscle Spasms/Cramps

Broken Bones Other: *None in this Category*

**Neurological:**

Numbness or tingling sensations Loss of Feeling



Dizziness or light headed Frequent or Recurrent Headaches Convulsions or seizures

Tremors Stroke

Have you ever had a head injury? Ever been in an auto accident?

Other:

*None in this Category*

**Mind/Stress:**

Nervousness Depression Sleep Problems



Memory Loss or Confusion

Other:

*None in this Category*

**Genitourinary:**

Sexual Difficulty Kidney Stones



Burning/Painful Urination

**Gastrointestinal:** Loss of Appetite Blood in Stool

Change in Bowel Movements Painful Bowel Movements Nausea or Vomiting Abdominal Pain



Frequent Diarrhea Constipation

Other:

*None in this Category*

**Cardiovascular & Heart:**

Chest Pains



Rapid or Heartbeat changes Blood Pressure Problems Swelling of Hands, Ankles, or Feet Heart Problems

Other:

*None in this Category*

**Respiratory:**

Difficulty Breathing Persistent Cough Coughing Blood Asthma or Wheezing Lung Problems



Other:

*None in this Category*

**Eyes and Vision:**

Wear contacts/glasses Blurred or double vision Glaucoma



Eye disease or injury

Other:

*None in this Category*

**Ears, Nose and Throat:**

Bleeding gums / mouth sores Bad Breath or bad taste Dental Problems



Swollen throat or voice change Swollen glands in neck

Ringing in the ears

**Endocrine, Hematologic, and Lymphatic:**

Thyroid problems Diabetes



Excessive Thirst or urination Cold Extremities

Heat or Cold intolerance Change in hat or glove size Dry skin

Glandular or hormone problem Swollen Glands

Anemia

Easily Bruise or Bleed Phlebitis

Transfusion

Immune system disorder

Other:

*None in this Category*

**Skin and Breasts:**

Rash or Itching Change in Skin Color Change in hair or nails Non-healing sores



Change of appearance of a mole Breast Pain

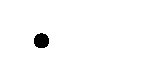
Breast Lump Breast Discharge

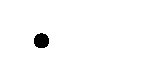
Other:

*None in this Category*

**Women Only:**

**Are you pregnant?**

**Yes - *Due Date* / /**

**No - *Last Menstrual Period***

**/ /**

Infertility



Painful or Irregular periods Vaginal Discharge

Other:

*None in this Category*

***Pregnancies with Outcome & Date:***



Change in force/strain w Urination



Frequent Urination Blood in Urine

Incontinence or Bed Wetting Other: *None in this Category*

Ear - Ache/Ringing/Drainage

Sinus / Allergy problems

Nose Bleeds Hearing Loss

Other:

*None in this Category*

*I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.*

Patient or Guardian Signature Date

# Welcome to Brookside Chiropractic!

## Appointment Reminders Preferences:

* I would like to receive appointment reminders via automated email the day of my appointment. Preferred Email Address:
* I would like to receive appointment reminders via automated text message the day of my appointment. Phone #: - - Phone Service Provider:
* I would prefer not to receive any appointment reminders from this office.

## HIPAA Notice:

I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is available for you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records please inform our office.

#### Patient’s Signature: (parent if minor) Date:

**Informed Consent for Chiropractic &/or Acupuncture Treatment:**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or of said minor) by Brookside Chiropractic Physicians and/or its employees. I understand and am 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, stroke, dislocations and sprains. In the practice of acupuncture there are some risks to treatment, including but not limited to minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, and stuck or bent needles. **Acupuncture points may have effects on pregnancy. Patients must inform the practitioner of any possibility of pregnancy at any point during the treatment process.** I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her, is in my best interest. I understand that results are not guaranteed. I have read, or have had read to me, the above consent. I have also had an opportunity to ask 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 any future condition(s) for which I seek treatment.

#### Patient’s Signature: (parent if minor) Date:

**Financial Policy**

Dear Patient:

Thank you for choosing us as your health care provider. The following is a description of our financial policy:

* Payment for services is due at the time services are rendered.
  + We accept cash, checks, Visa, MasterCard, Discover, and American Express.
  + We will be happy to assist you with applying for financing should you so desire.
  + We reserve the right to collect before services are rendered.
* All charges are your responsibility whether the insurance company pays or not.
  + Not all services are a covered out of net-work benefit. Benefits may vary on different insurance plans. It is your responsibility to verify your insurance coverage.
* It is our policy to collect 100% payment at the time the services are rendered.
* We understand that temporary financial problems may affect timely payment of your balance. We ask that you speak with an Account Manager if you encounter such problems, so that we may assist you in the management of your account.

Again, thank you for selecting us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Patient’s or Guarantor’s Signature Date

Witness Signature Date

Patient Name: Date:

**Appointment Reminders and Health Care Information Authorization**

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with these reminders/information and understand that…

***(Please place a line through any method that you REFUSE to be contacted by and initial.)***

### I may be *contacted* by: phone at home or work, mobile phone, e-mail, or postcard.

Email:

Phone:

*Messages* may be left: on answering machine/voicemail at home, work, and on mobile phone. Or with *individuals answering my phone* at home, or at work.

Information that we use or disclose based on this authorization may be subject to re-disclosure by anyone who has access to the reminder or information and may no longer be protected by the federal privacy rules.

You may restrict the individuals or organizations to which your health care information is released, or revoke your authorization at any time; however, the revocation must be in writing and will become effective once we receive the revocation. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse any part of this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

I authorize the use or discloser of my health information as described above. This notice is effective as of the date below and expires seven years from the date I last received services in this office.

Patient Signature Authorized provider representative

Personal representative Printed Personal representative signature

Description of personal representative’s authority to act for the patient.