KC North
SPINE & JOINT CENTER

Confidential Patient Information

Park Hill Office:
8303 N Congress Ave
Kansas City, MO 64152
P: 816-584-0413
F: 816-584-0453
office@kcnorthsjc.com

Liberty Office:
1528 N.E. 96th St. Ste. B
Liberty, MO 64068
P: 816-415-3515
F: 816-415-3519
liberty@kcnorthsjc.com

Date:_____/_____/_____

Patient's Full Name _____Preferred Name (nickname)_____

Mailing Address:_____ City:_____ State:____ Zip:_____

Preferred Phone #: _____ Alternate Phone #: _____ E-Mail: _____

Date of Birth:_____/____/_____ □ Male □ Female Do you have a spouse? _____ Do you have children? _____

How were you referred to our office? Please be specific:_____

Occupation:_____ Employer:_____ Employer City:_____

What is your long-term goal from treatment (e.g. walk or run a 5k, play a round of golf, play with your kids, work without pain)?

_____

_____

Is Today's Visit Due To A Work Related Injury: □ Yes □ No **Is Today's Visit Due To An Auto Accident:** □ Yes □ No

****If yes to either questions above, please check with receptionist, additional information is needed

Current Health History:

Main (One only) complaint that has brought you in:_____

Secondary or related complaint(s) if any:_____

PAIN CHART

Please Mark the Areas of Pain using these Symbols & Mark Severity of Pain to the Left

+++ Burning **XXX Dull/Ache** **/// Numbness/Tingling** **=== Throbbing** **000 Stabbing/Sharp**

SEVERITY OF PAIN

1. Complaint _____

0 1 2 3 4 5 6 7 8 9 10

No pain Unbearable

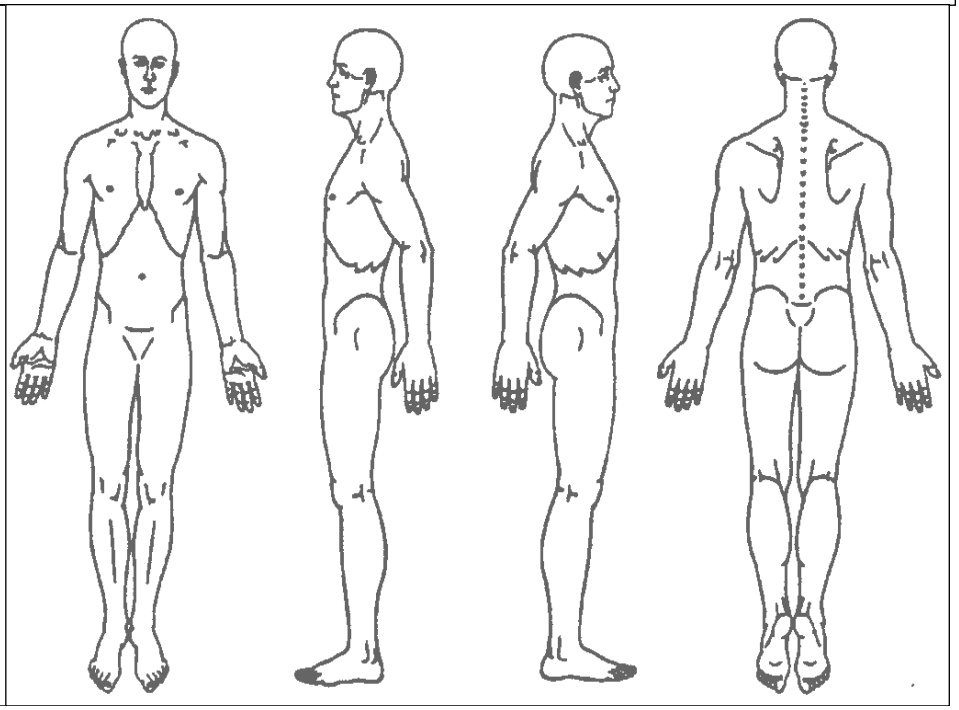
2. Complaint _____

0 1 2 3 4 5 6 7 8 9 10

No pain Unbearable

3. Complaint _____

0 1 2 3 4 5 6 7 8 9 10



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Current Health History Continued:

Describe what caused the pain (if you know):_____

When did your symptoms begin?: _____ Did the pain start: □ Gradually □ Suddenly □ Trauma-induced

Since it started, has it gotten: □ Worse □ Better □ Stayed the same

What makes your current condition(s) better?_____

What makes your current condition(s) worse?_____

Does the pain/complaint radiate or travel from one part of your body to another? Where? _____

Are your symptoms worse during a particular part of the day/night? _____

Have you detected any possible relationship of your current complaint with any of the following:

□ Bowel/Bladder problems □ Digestion □ Cardiac/Respiratory □ Other:_____

Have you tried any medication (over the counter or prescription): □ Yes □ No

If yes, what:_____Results:_____

What other medications are you currently taking?_____

Have you ever experienced your present problem before for which you are consulting us: □ Yes □ No If yes, When:_____

Was treatment provided: □ Yes □ No If yes, By whom:_____ Outcome:_____

Recreational Activities (Hobbies):_____

Do you exercise? _____ Do you smoke? _____ How many hours of sleep do you normally get?_____

How much water do you drink per day?_____ Do you drink coffee, soda, or tea regularly?_____

Is work stressful to you? _____ Is family life stressful to you? _____

Have you **ever** had a **stroke** or issues with **blood clotting**? □ Yes □ No If yes, when: _____

Are you currently taking anti-coagulant or blood thinning medication? □ Yes □ No

Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? □ Yes □ No

Have you **ever** had any **injuries, broken bones, hospitalizations, accidents, or surgeries in the area of the complaint?** □ Yes □ No

If yes, please explain: _____

_____

Do you have any other illnesses or medical issues that you feel the doctor should be aware of? _____

Do you ever have jaw pain or ever been told you clinch/grind your teeth?_____

Who is you primary care physician? _____ phone # _____

Can we contact him/her?_____ ***We like to communicate our care with your PCP if possible***

Are you currently pregnant*? □ Yes □ No □ n/a *Who is your current OBGYN/Mid-Wife/Doula?_____

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Rehabilitative exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware the there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of Patient Date_____

_____Signature of Parent or Guardian Date_____

(if a minor)

Financial/Privacy Policy & Disclaimer and Authorization

Payment

- Due at Time of Service

Returned Checks

- It is our policy to collect $25.00 for checks that are returned to us. This is to cover any fees that apply from the transaction.

Appointments

- If unable to keep an appointment, as a courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem there will be a $20 charge added towards your account each visit that is missed. The patient will be responsible for payment.

Financial Policy Questions

- We are happy to address questions regarding you account at any time. Please direct accounting questions to our billing administrator, Dara Gaudin.

HIPAA Privacy Policy

- Available at the front desk is the HIPAA Notice of Privacy Practices Policy for you**.** By signing below, the patient acknowledges that he/she has had the HIPAA Privacy Policy made available to him/her and will comply with our financial policies.

Designation of Authorized Representative

- I do hereby designate KCNSJC to the full extent permissible under the Employee Retirement income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to obtain any medical records that are pertinent to my current condition that has led me to seek care from KCNSJC.
- You are authorized to release any information you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.

_____ _____

patient signature **date**

Insurance Patients ONLY:

- I authorize my attorney and/or any insurance company to make direct payment to you of settlement proceeds.
- I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, **I personally owe to you**.
- I further agree that this Authorization and Assignment is irrevocable until all moneys owed to KC North Spine & Joint Center are **paid in full**.

_____ _____

patient signature **date**