INTRODUCTION PATIENT CASE HISTORY

Today's Date: ____/____/_____

PATIENT INFORMATION

Name: *(First MI Last)* ________________________________ **Preferred Name:** ____________

Address: ____________________________ **City:** ____________ **State:** ______ **Zip:** __________

Date of Birth: __________ **Gender:** ☐ Male ☐ Female **Social Security #:**____________

Home: ____________ **Mobile:** ____________ **Work:** ____________

Email: ______________________________

Preferred Method of Contact: ☐ Text ☐ Email ☐ Phone - *Home, Mobile, or Work* ☐ Other: __________

***Referred By:** *(Name)* ____________________

☐ Family ☐ Friend ☐ Co-Worker ☐ Doctor ☐ Other: __________

Race & Ethnicity: *(Choose up to 2)*

☐ African American or Black
☐ American Indian or Alaskan Native
☐ Asian
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Decline

Preferred Language:

☐ English
☐ Spanish
☐ Other: __________
☐ Decline

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* ________________________ **Primary Care Physician:** ________________

Home: ____________ **Mobile:** ____________ **Doctor's Phone:** ____________________

Relationship:

☐ Child ☐ Parent ☐ Spouse ☐ Other: __________

FINANCIAL INFORMATION

Is today's visit the result of an accident?

☐ No ☐ Auto ☐ Work ☐ Other: __________

Will we be working with insurance? ☐ No ☐ Yes *(Details)*

Primary: ________________ *ID#:* __________

Secondary: ________________ *ID#:* __________

Where would you like statements sent?

☐ Self ☐ Other *(Details below)*

Name: ______________________________

Address: ______________________________

Phone: ____________ *Email:* ____________

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature ______________________________ Date____________

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

Account No: __________

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HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS *(Please describe)*

Major Complaint: ____________________________________

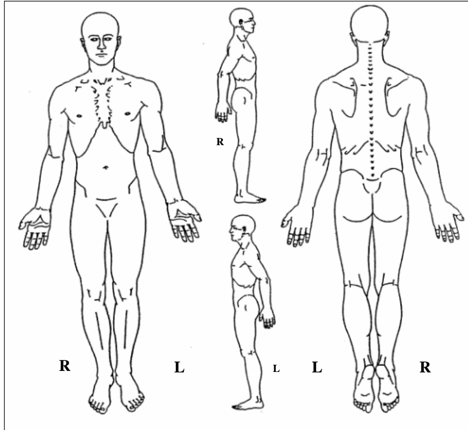
Secondary Complaints: ________________________________

When did it start? ____/____/_____ **What happened?** ______________________________

Which daily activities are being affected by this condition? ______________________________

MAJOR COMPLAINT

Location of Symptoms and Radiation



P __ Pain
N __ Numb
S __ Spasm
T__ Tender
H__ Hypoesthesia

Grade Intensity/Severity:

- ☐ None (0/10)
- ☐ Mild (1-2/10)
- ☐ Mild-Moderate (2-4/10)
- ☐ Moderate (4-6/10)
- ☐ Moderate-Severe (6-8/10)
- ☐ Severe (8-10/10)

Frequency:

- ☐ Off & On
- ☐ Constant

Quality:

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy
- ☐ Dull
- ☐ Stiff & Sore
- ☐ Other: ________________

Does it radiate?

☐ No ☐ Yes *(Please indicate on drawing)*

Improves with:

- ☐ Ice
- ☐ Heat
- ☐ Movement
- ☐ Stretching
- ☐ OTC Medications: ______________
- ☐ Other: ______________________

Worsens with:

- ☐ Sitting
- ☐ Standing/Walking
- ☐ Lying Down/Sleeping
- ☐ Overuse/Lifting
- ☐ Other: ________________________

Previous Treatment:

- ☐ None
- ☐ Chiropractor ___________________
- ☐ Medical Doctor _________________
- ☐ Physical Therapy _______________
- ☐ ER/Urgent Care ________________
- ☐ Orthopedic ____________________
- ☐ Other: ________________________

Previous Diagnostic Testing:

- ☐ None
- ☐ X-rays _________________________
- ☐ MRI ___________________________
- ☐ CT ____________________________
- ☐ Other: ________________________

***Women:** *Are you pregnant?*

☐ No *Last Menstrual Period:* ___/___/____

☐ Yes *Due date:* ___/___/____

Present Illness Comments:

Prescription Medications & Supplements: ☐ None

☐ Yes *(List – Name, dosage, frequency)* ________________________

Allergies to Medications: ☐ No known drug allergies

☐ Yes *(List - Name and reaction)*____________________________

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Revision Date 03/14/2017

PAST, FAMILY, AND SOCIAL HISTORY

PAST MEDICAL HISTORY

Have you *ever* had any of the following? *(Please select all that apply and use comments to elaborate.)*

Illnesses:
- ☐ Asthma
- ☐ Autoimmune Disorder (*Type*) ________
- ☐ Blood Clots
- ☐ Cancer (*Type*) ____________________
- ☐ CVA/TIA (stroke)
- ☐ Diabetes
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Other: _________________________

____

____

Injuries:
- ☐ Back Injury
- ☐ Broken Bones
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Falls
- ☐ Other: _________________________

Hospitalizations: *(Non-surgical with Date)*

____

____

Surgeries: *(If yes, provide type & surgery date)*
- ☐ Cancer _________________________
- ☐ Orthopedic
  - Shoulder – R / L ____________
  - Elbow/Forearm – R / L ____________
  - Wrist/Hand – R / L ____________
  - Hip – R / L ____________
  - Knee – R / L ____________
  - Ankle/Foot – R / L ____________
- ☐ Spinal Surgery
  - Neck: ________________________
  - Back: ________________________
- ☐ Other: _________________________

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Medical History Comments:

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FAMILY HISTORY *(Please mark **X** to all that apply and use comments to elaborate.)*

☐ Unknown ☐ Unremarkable

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death *(if Deceased)*								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

Family History Comments:

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SOCIAL AND OCCUPATIONAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Children: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other:________________

Student Status: ☐ Full Student ☐ Part Student ☐ Non-Student

Highest level of Education: ☐ High School ☐ College Grad.

☐ Post Grad. ☐ Other: ________________________________

Employed: ☐ No ☐ Yes (*Occupation*) ______________________

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Smoking/Tobacco Use: *If current smoker, amount =* __________

☐ Every Day ☐ Some Days ☐ Former ☐ Never

Alcohol Use:

☐ Every Day ☐ Weekly ☐ Occasionally ☐ Never

Caffeine Use:

☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Soda ☐ Never

Exercise frequency:

☐ Daily ☐ 3-4xs/week ☐ 2-3xs/week ☐ Rarely ☐ Never

Social History Comments: ________________________________

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Revision Date 03/14/2017

REVIEW OF SYSTEMS

Many of the following conditions respond to chiropractic treatment.

Are you *currently* experiencing any of these symptoms? *(Please select all that apply and use comments to elaborate.)*

Constitutional: *(General)*
- ☐ Fever
- ☐ Fatigue
- ☐ Other: ______________________
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Joint Pain/Stiffness/Swelling
- ☐ Muscle Pain/Stiffness/Spasms
- ☐ Broken Bones_________________
- ☐ Other: ______________________
- ☐ *None in this Category*

Neurological:
- ☐ Dizziness or Lightheaded
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Other: ______________________
- ☐ *None in this Category*

Psychiatric: *(Mind/Stress)*
- ☐ Nervousness/Anxiety
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: ______________________
- ☐ *None in this Category*

Genitourinary:
- ☐ Frequent or Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Painful or Irregular Periods
- ☐ Other: ______________________
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool or Black Stool
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: ______________________
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains/Tightness
- ☐ Rapid or Heartbeat Changes
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Other: ______________________
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Other: _________________
- ☐ *None in this Category*

Eyes & Vision:
- ☐ Eye Pain
- ☐ Blurred or Double Vision
- ☐ Sensitivity to Light
- ☐ Other: ______________________
- ☐ *None in this Category*

Head, Ears, Nose, & Mouth/Throat:
- ☐ Frequent or Recurrent Headaches
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Hearing Loss
- ☐ Sensitivity to Loud Noises
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Other: ______________________
- ☐ *None in this Category*

Endocrine:
- ☐ Infertility
- ☐ Recent Weight Change
- ☐ Eating Disorder
- ☐ Other: ______________________
- ☐ *None in this Category*

Hematologic & Lymphatic:
- ☐ Excessive Thirst or Urination
- ☐ Cold Extremities
- ☐ Swollen Glands
- ☐ Other: ______________________
- ☐ *None in this Category*

Integumentary: *(Skin, Nails, & Breasts)*
- ☐ Rash or Itching
- ☐ Change in Skin, Hair, or Nails
- ☐ Non-healing Sores or Lesions
- ☐ Change of Appearance of a Mole
- ☐ Breast Pain, Lump, or Discharge
- ☐ Other: ______________________
- ☐ *None in this Category*

Allergic/Immunologic:
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Other: ______________________
- ☐ *None in this Category*

Review of Systems Comments:

____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature ____ Date______________________

Print Name: *(First MI Last)* ____

Account No: ______

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Revision Date 03/14/2017

Oswestry Low Back Pain Disability Questionare

Section 1 : Pain Intensity

- o I have no pain at the moment
- o The pain is very mild at the moment
- o The pain is moderate at the moment
- o The pain is fairly severe at the moment
- o The pain is very severe at the moment
- o The pain is worst imaginable at the moment

Section 2 : Personal Care

- o I can look after myself normally without causing extra pain
- o I can look after myself normally but it causes pain
- o It is painful to look after myself and I am slow and careful
- o I need some help but can manage most of my personal care
- o I need help everyday in most aspects of personal care
- o I do not get dressed, wash with difficulty and stay in bed

Section 3 : Lifting

- o I can lift heavy weight without extra pain
- o I can lift heavy weight, but it gives me extra pain
- o Pain prevents me from lifting heavy weight from the ground
- o I can lift medium weight if conveniently placed on table
- o I can only lift very light weight
- o I cannot lift or carry anything at the moment

Section 4: Walking

- o Pain does not prevent me from walking any distance
- o Pain prevents me from walking more than 1 mile
- o Pain prevents me from walking more than 1/2 mile
- o Pain prevents me from walking more than 100 yards
- o I can only walk using a stick or crutches
- o I am in bed or sitting most of the time

Section 5 : Sitting

- o I can sit in any chair as long as I like
- o I can only sit in my favorite chair as long as I like
- o Pain prevents me from sitting longer than 1 hour
- o Pain prevents me from sitting longer than 30 minutes
- o Pain prevents me from sitting longer than 10 minutes
- o Pain prevents me from sitting for any length of time

Section 6: Standing

- o I can stand as long as I want without extra pain
- o I can stand as long as I want but it gives me extra pain
- o Pain prevents me from standing more than 1 hour
- o Pain prevents me from standing longer than 30 minutes
- o Pain prevents me from standing longer than 10 minutes
- o Pain prevents me from standing at all

Section 7 : Sleeping

- o My sleep is never disturbed by pain
- o My sleep is occasionally disturbed by pain
- o Because of pain, I have less than 6 hours of sleep
- o Because of pain, I have less than 4 hours of sleep
- o Because of pain, I have less than 2 hours of sleep
- o Pain prevents me from sleeping at all

Section 8 : Sex Life (if applicable)

- o My sex life is normal and causes no extra pain
- o My sex life is normal but causes some extra pain
- o My sex life is nearly normal but is very painful
- o My sex life is severely restricted by pain
- o My sex life is nearly absent because of pain
- o Pain prevents any sex life at all

Section 9 : Social Life

- o My social life is normal and gives me no extra pain
- o My social life is normal but increases the degree of pain
- o Pain only affects my social life by limiting any energetic activities
- o Pain restricts my social life and I do not go out as often
- o Pain has restricted my social life to my home
- o I have no social life because of pain

Section 10 : Traveling

- o I can travel anywhere without pain
- o I can travel anywhere but it gives me extra pain
- o Pain worsens but I manage journeys over 2 hours
- o Pain restricts me to journeys of less than 1 hour
- o Pain restricts me to necessary journeys under 30 minutes
- o Pain prevents me from any travel, unless required or necessary

Name: Date:

Jensen Chiropractic & Acupuncture
1620 Locust Street, Suite 100 Kansas City MO 64108 816.363.3500
Revised 07.25.2016

Patient Name: ________________________________ D.O.B.:_____________ Date:___________

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation and examination on the above.

AUTHORIZATION FOR X-RAY WITH RELEASE: By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGEMENT: By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

Signature of Patient: ____

Signature of Parent or Guardian: __________________________________