Capitol City Chiropractic

1835 NW Topeka Blvd
Suite 209
Topeka, KS 66608
785-234-0900

Medical History Information
CHIROPRACTIC

Personal Information					
Patient Name:			❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. ❑ Dr.	Marital status (circle one) S M W D	
Address:					
City:	State:	Zip:	Birth date:	Age:	Sex:
Email Address: ☐ Home ☐Work			Social Security #:		
Home Phone:	Cell Phone:		Work phone:		
How would you prefer we contact you? ☐ Home ☐ Cell or ☐ Work Phone					
Employer:			Occupation:		

How Did You Hear About Our Office? CIRCLE ONE:

Former Patient Office Sign Attorney CCC Staff TBC CPLS Google Search Yahoo Search

Yellow Book Newspaper Phonebook Facebook Christian Directory

Patient Referral: _____ Other:_____

Medical Care Information			
Do You Have a Family Doctor?: ☐ No ☐ Yes	Name of Doctor:		
City	State:	Zip Code:	Date of last Visit: / /
Have you been to a Chiropractor in the past? ☐ No ☐ Yes	Name of Chiropractor:		
City:	State:	ZIP Code:	Date of last Visit: / /
Have you had surgeries in the last 5 Years: ☐ Yes ☐ No	If yes, Last Surgery Date:		
Reason for Surgery:			

Emergency Contact Information		
Emergency Contact Name:	Phone #:	
Address:	State:	Zip Code:

Social History:			
Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous
Misc.:			

Present Illness /Conditions:					
☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐ Headaches
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐ Other
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	

Patient Review of Systems: (Mark any you are currently experiencing)					
☐ Chills	☐ Difficulty Swallowing	☐ Constipation/Diarrhea	☐ Nausea / Vomiting	☐ Cold Intolerance	☐ Difficulty Urination
☐ Fatigue	☐ Blurred Vision	☐ Heart Palpitations	☐ Seizures	☐ Heat Intolerance	☐ Blood in Urine
☐ Fever	☐ Eye Irritation	☐ Fainting	☐ Vertigo	☐ Excessive Thirst	☐ Incontinence
☐ Weight change	☐ Decreased Hearing	☐ Abdominal Pain	☐ Anxiety	☐ Hay Fever	☐ Itching
☐ Sore Throat	☐ Light sensitivity	☐ Chest Pains	☐ Memory Loss	☐ HIV Exposure	☐ Rash
Other:					

Current Medications/Supplements (Please list or attach name and dosage):

Where are you purchasing your medications/supplements?_____

Patient Consent for Treatment / Acknowledgement of Receipt of Notice of Privacy Practices

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Capitol City Chiropractic, Inc. and its associated doctors and other personnel. I am aware that the practice of health care is not an exact science and I further state that I understand that no guarantee has been or can be made as to the result of the treatments or examinations at Capitol City Chiropractic, Inc.

2. I consent to the use and disclosure of my/the patient's protected health information for purposes obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Capitol City Chiropractic, Inc. Notice of Privacy Practices.

3. I authorize payment of medical benefits to Capitol City Chiropractic, Inc. or their designee for services rendered.

4. I acknowledge I was offered a copy of the Notice of Privacy Practices for Capitol City Chiropractic, Inc., effective May 22, 2006.

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

For Women Only:

To the best of my knowledge I am NOT pregnant and Dr. Chance has my permission to x-ray me for diagnostic interpretation if determined necessary.

_____ _____

Patient or Authorized Person's Signature Date

Financial Policy and Disclosure

Please Sign and Date

Patients are responsible for payment of all services provided by Capitol City Chiropractic, Inc. (CCC)

Private Pay Policy

- As a Private Pay patient, you will be expected to pay for the office visit at the time services are rendered, unless other arrangements have been made with the Office Manager.
- In addition, any remaining balance on your account will be collected at discharge.

Medicare Policy

- We file insurance with Medicare as a courtesy to you, if we have accurate and complete insurance information**. Deductibles, co-payments, and coinsurance will be collected at the time services are rendered.**
- All other insurances are considered out of network. We encourage you to be familiar with your policy benefits, exclusions, limitations and maximums.

Workers Compensation/Auto Accident Policy

- If you are a workers compensation patient, it is our policy to bill your employer or the worker's compensation carrier for services rendered. We will provide Workers' Compensation Authorization for Treatment form that you will be responsible to give to your employer to complete and return back to our office with the name and address of your employer or the insurance company that covers your employer.
- If you are an auto accident patient, we will continue care under a "Letter of Protection" from a licensed attorney. Auto insurance or the use of personal injury protection coverage is also acceptable, provided we verify claim status prior to service with insurance adjuster.
- If you are covered under worker's compensation or auto insurance, we will accept the payments by the insurance carrier as per contracted rates based on the mandated state fee schedule. <u>If payment is denied, you will be responsible for the entire balance of your services.</u>

X-ray Policy

- It is understood and agreed that the amount paid for x-rays is for diagnostic information only and the x-ray negative will remain property of Capitol City Chiropractic, Inc.

Collections Policy

- If your bill remains unpaid after 60 days, a notice will be issued along with a second statement. After 90 days without payment your account will be forwarded to collections and settlement will occur within them. Please indicate here if you would prefer a notice by phone. _____
  If left blank, email will be the primary means of notice.

Divorced or Custody Case Policy

- The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in the divorce decree, or who has custody, or who has the insurance.

Missed Appointment Fee

- We reserve the right to charge a $25.00 late fee on missed appointments. Please call us 24 hours prior to your visit, if you need to reschedule your appointment.

To help in this policy, we ask that you assist us by:

- Providing us with current and updated information on you.
- Presenting an updated photo identification card when changes are made.
- Making the appropriate payment at the time of service.

I have read and understand the above information. I also understand that I am responsible for all costs of my treatment regardless of what my insurance carrier may or may not pay.

_____ _____

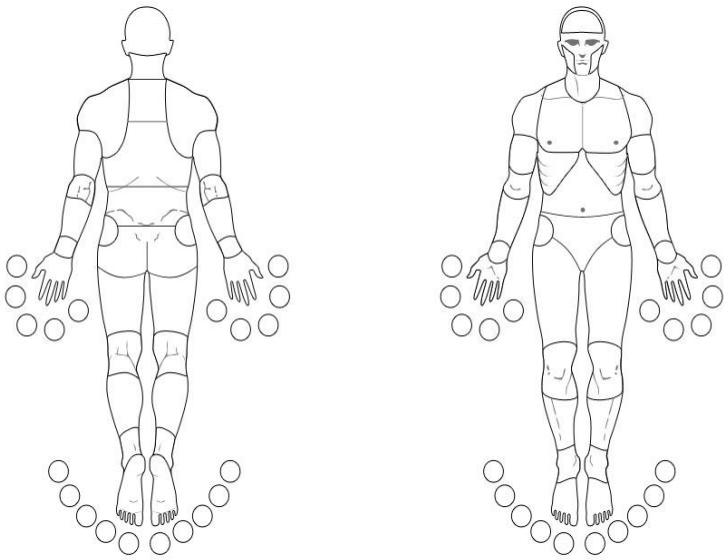
Patient or Authorized Person's Signature Date

CURRENT COMPLAINTS

Name: _____

Please indicate the current complaints you are experiencing by marking the areas on the image below and providing details using the sections that follow.

Headaches	Leg
Neck	Calf
Upper back	Shin
Mid Back	Ankle
Lower Back	Foot
Hip	Toes
Buttock	Chest
Shoulder	Ribs
Arm	Abdomen
Elbow	Pelvis/Groin
Forearm	Wrist
Fingers	Hand
Knee	



******Use only one section per area of complaint******

1st Area of Complaint:		
Location		Left Right Both Center
Pain Rating		0 1 2 3 4 5 6 7 8 9 10 (Excruciating)
Frequency		Infrequent < 25% Occasional 25% to 50% Frequent 50% to 75% Constant > 75%
Pain Type		No Pain Pain Numbness Tingling Muscle Spasms Burning
Severity		Mild Mild to Moderate Moderate Moderate to Severe Severe
What makes it better?		Medication Lying Down Standing Sitting Stretching Range of Motion Nothing
What makes it worse?		Movements Bending Twisting Weight Bearing Walking Neck flexion Sneezing Sitting Standing Chewing Yawning Lifting Opening mouth Closing mouth Range of motion pushing/pulling Loud Noise Watching T.V. Reading Working Driving Housework Bright lights Nothing
Does the pain radiate to any other locations?	Upper Body	Head Forehead Back of head Right side of head Left side of head Right Ear Left Ear Right Eye Left Eye Face Right Jaw Left Jaw Right Upper back Left Upper back Right Shoulder Left Shoulder Right Chest Left Chest Right Ribs Left Ribs
	Mid Body	Right Mid back Left Mid back Right Lower back Left Lower back Right Hip Left Hip Right Buttock Left Buttock Groin Right Arm Left Arm Right forearm Left forearm Right hand Left hand Right fingers Left fingers
	Lower Body	Right Thigh Left Thigh Right Knee Left Knee Right Calf Left Calf Right Toes Left Toes Right Foot Left Foot
Described as		Aching Dull Sharp Stabbing Throbbing Stiffness
At it's worst		Morning Afternoon Evening Night *After Activities*: Light or Moderate
Associated with		Dizziness Nausea Visual Problems Ringing/Buzzing ears Bright light Sensitivity Loss of balance

_____ _____

Patient or Authorized Person's Signature Date

2nd Area of Complaint:		
Location		Left Right Both Center
Pain Rating		0 1 2 3 4 5 6 7 8 9 10 (Excruciating)
Frequency		Infrequent < 25% Occasional 25% to 50% Frequent 50% to 75% Constant > 75%
Pain Type		No Pain Pain Numbness Tingling Muscle Spasms Burning
Severity		Mild Mild to Moderate Moderate Moderate to Severe Severe
What makes it better?		Medication Lying Down Standing Sitting Stretching Range of Motion Nothing
What makes it worse?		Movements Bending Twisting Weight Bearing Walking Neck flexion Sneezing Sitting Standing Chewing Yawning Lifting Opening mouth Closing mouth Range of motion pushing/pulling Loud Noise Watching T.V. Reading Working Driving Housework Bright lights Nothing
Does the pain radiate to any other locations?	Upper Body	Head Forehead Back of head Right side of head Left side of head Right Ear Left Ear Right Eye Left Eye Face Right Jaw Left Jaw Right Upper back Left Upper back Right Shoulder Left Shoulder Right Chest Left Chest Right Ribs Left Ribs
	Mid Body	Right Mid back Left Mid back Right Lower back Left Lower back Right Hip Left Hip Right Buttock Left Buttock Groin Right Arm Left Arm Right forearm Left forearm Right hand Left hand Right fingers Left fingers
	Lower Body	Right Thigh Left Thigh Right Knee Left Knee Right Calf Left Calf Right Toes Left Toes Right Foot Left Foot
Described as		Aching Dull Sharp Stabbing Throbbing Stiffness
At it's worst		Morning Afternoon Evening Night *After Activities*: Light or Moderate
Associated with		Dizziness Nausea Visual Problems Ringing/Buzzing ears Bright light Sensitivity Loss of balance

3rd Area of Complaint:		
Location		Left Right Both Center
Pain Rating		0 1 2 3 4 5 6 7 8 9 10 (Excruciating)
Frequency		Infrequent < 25% Occasional 25% to 50% Frequent 50% to 75% Constant > 75%
Pain Type		No Pain Pain Numbness Tingling Muscle Spasms Burning
Severity		Mild Mild to Moderate Moderate Moderate to Severe Severe
What makes it better?		Medication Lying Down Standing Sitting Stretching Range of Motion Nothing
What makes it worse?		Movements Bending Twisting Weight Bearing Walking Neck flexion Sneezing Sitting Standing Chewing Yawning Lifting Opening mouth Closing mouth Range of motion pushing/pulling Loud Noise Watching T.V. Reading Working Driving Housework Bright lights Nothing
Does the pain radiate to any other locations?	Upper Body	Head Forehead Back of head Right side of head Left side of head Right Ear Left Ear Right Eye Left Eye Face Right Jaw Left Jaw Right Upper back Left Upper back Right Shoulder Left Shoulder Right Chest Left Chest Right Ribs Left Ribs
	Mid Body	Right Mid back Left Mid back Right Lower back Left Lower back Right Hip Left Hip Right Buttock Left Buttock Groin Right Arm Left Arm Right forearm Left forearm Right hand Left hand Right fingers Left fingers
	Lower Body	Right Thigh Left Thigh Right Knee Left Knee Right Calf Left Calf Right Toes Left Toes Right Foot Left Foot
Described as		Aching Dull Sharp Stabbing Throbbing Stiffness
At it's worst		Morning Afternoon Evening Night *After Activities*: Light or Moderate
Associated with		Dizziness Nausea Visual Problems Ringing/Buzzing ears Bright light Sensitivity Loss of balance

Authorization for Release of Protected Health Information (PHI) Form

There are times when you want your PHI released to other individuals like a spouse, parent, guardian or other family members. Your records are confidential. In order to release any PHI we will need your signed consent to release your PHI. Release of PHI includes both written records and verbal information.

Patient authorizing release:

_____ _____

First Name Last Name

_____

Street Address

_____ _____ _____

City State Zip

_____

Date of birth

I hereby give my authorization to disclose my protected health information to the following individual(s):

_____ _____

First Name Last Name

_____ _____ -- _____ -- _____

Relationship Phone Number

_____ _____

First Name Last Name

_____ _____ -- _____ -- _____

Relationship Phone Number

Please mark one of the following options:

____ Disclose all medical information to the above listed individual(s)

____ Only disclose the following specific information to the above listed individual(s)

_____

_____

_____

I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. This authorization is valid permanently or until such time as written revocation has been received by Capitol City Chiropractic. In addition, I understand that I may revoke this authorization at any time by notifying Capitol City Chiropractic in writing and that the revocation of this authorization will not affect any action taken in reliance of this authorization before the written revocation was received.

_____ _____

Signature Date