Capitol City Chiropractic

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

Medical History Information

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					
How did you hear about our office?:					

Patient Employment Information	
Employer Name:	Occupation:

Insurance Information			
Insurance Company:			
Policyholder's Name:		Policyholder's Date of Birth:	
Address:	City:	State:	Zip:

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:

Responsible Party's Information (If patient is minor)			
Legal Name:	Phone #:	Social Security #:	
Address:	City:	State:	Zip:

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:					

Complete only if you were in an AUTOMOBILE ACCIDENT:	
Patient's Auto Insurance Company's Name:	
Have you filed a medical claim with <u>your</u> insurance company? ☐ No ☐ Yes	
Adjuster's Name:	
Claim Number:	Telephone Number:

Complete only if you were in a WORK RELATED ACCIDENT:	
Employer's Name:	Supervisor's Name
Address of Employer:	
Telephone Number of Employer:	
Name of Insurance Company / Lawyer:	
Address:	Telephone Number:
Insurance Claim Number:	
Job Description:	
How many hours do you work per week?	

Patient Consent for Treatment

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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

☐ I acknowledge I have received a copy of the Notice of Privacy Practices for Capitol City Chiropractic, Inc., effective May 22, 2006.

☐ I am choosing not to receive a copy of the Notice of Privacy Practices.

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/Dr. Oller 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

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating requirements for payments for services provided to patients.

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

Self-Pay Policy

- If you are a self pay patient, you will be required to pay for the office visit at the time services are rendered.
- In addition, any remaining balance on your account will be collected at discharge.

Insurance Policy

- If you are an insurance patient with Blue Cross Blue Shield, Century, and Medicare it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- If we have not received a payment from your insurance company within forty-five (45) days, you will be responsible for the balance due.
- Deductibles, co-payments, and coinsurance will be collected at the time services are rendered.
- In special cases, we may need your help in contacting your insurance company for the payment of your services.

Workers Compensation 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.
- If you are covered under worker's compensation, we will accept the payments by the worker's compensation carrier as per contracted rates based on the mandated state fee schedule.
- If payment is denied from your worker's compensation carrier, you will become responsible for the entire balance of your services. Payment will be due within thirty (30) days following any worker's compensation payment denial.
- It will be your responsibility to contact us with the name and address of your employer or the insurance company that covers your employer.
- 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.

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.
- You will be responsible for the cost of this service if your insurance company chooses not to cover it.

Overdue Balances

- All over-due patient balances will be sent to collections.
- All accounts sent to collections will be charged a $25.00 collection fee in addition to the account balance.

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.

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

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or the full amount if you are a Self-Pay Patient.

In order to provide the best care, we ask that you <u>do not</u> discuss your account balance or financial aspects with the doctor(s). Please discuss any account information with the Chiropractic Assistant (CA) at the front desk.

_____ _____

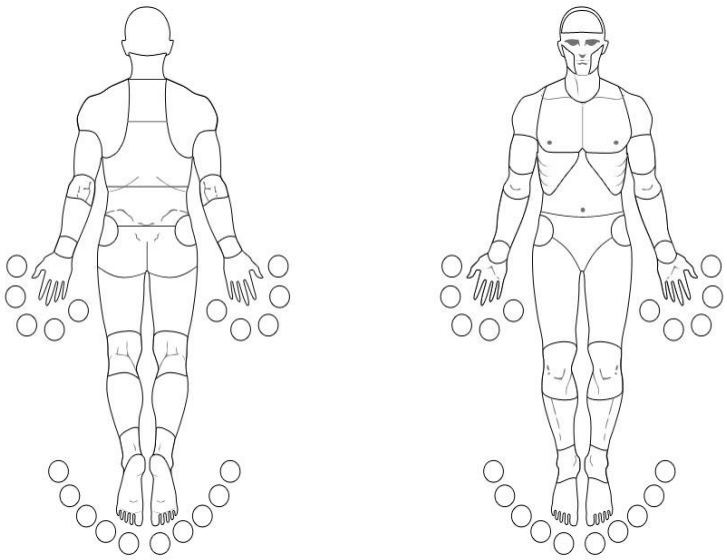
Patient or Authorized Person's Signature Date

CURRENT COMPLAINTS

Name: _____ Date: _____

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
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

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
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
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