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 #**:_____

Cell phone: _____

Is Home ph same as Cell? Y N (list if different)__ _____

Work: _____

Email: _____

***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:* _____

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?** _____

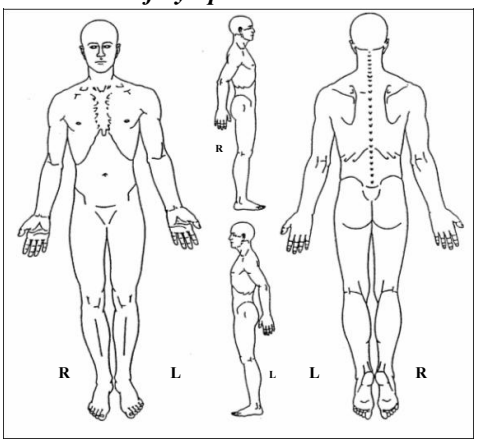
_____

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)*_____

_____

_____

_____

_____

_____

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: _____

_____

_____

Medical History Comments:

_____

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:

_____

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: _____

REVIEW OF SYSTEMS

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____________________

Informed Consent Chiropractic, Acupuncture, and Therapeutic Procedures

To make better informed decision to consent to treatment, please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

Chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications including but not limited to needle acupuncture: bleeding, infection, punctured lung, increased or no improvement in pain & symptoms, sprain/strain injuries, irritation of a condition, dislocation, temporary minor dizziness, nausea, paralysis, vision loss, possible locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), up to and including death. Fractures are rare occurrences and generally result from some underlying weakness of the bone which is checked for during the taking of your history and during examination and X-ray. The causes of stroke, cerebral vascular accident (CVA), vertebral artery dissection are the subject of tremendous disagreement. The debated incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. Although some reports have associated upper high velocity neck manipulation with a certain kind of stroke, or vertebral artery dissection, there is not yet a clear understanding of the connection.

Availability and nature of other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization & injections
- Surgery

** If you chose to use any of the above noted "other treatment" options, you should be aware that there are possible risks: side effects even including death, and benefits you may wish to discuss these with your primary medical physician.

The provider will make every reasonable effort during the examination to screen for contraindications to care; however, if the patient has a condition that would otherwise not come to the doctor's attention, it is the patient's responsibility to inform the doctor. Although a reasonable effort has been made, I the patient do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT PLAN: Consult Examination X-rays Chiropractic Therapies Acupuncture

Having read or had read the consent, I the patient have had the opportunity to ask questions & discuss with Dr. Rostberg, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all. All of my questions have been answered to my satisfaction. I request and consent to chiropractic adjustments and other chiropractic & acupuncture procedures, including various modes of therapy and diagnostic X-rays. The chiropractic & acupuncture treatment may be performed by Dr. Rostberg

By signing below, I consent to the treatment. I also intend this consent form to cover my entire clinical course of treatment here.

Print Patient Name_____

Patient Signature_____Date signed_____

Print Patient Representative_____Relationship to Patient_____

Signature of Parent or Guardian _____Date signed_____

(if a minor)

Staff Witness to above signature_____Date_____

Continued next page….

Rostberg Chiropractic & Acupuncture 10520 Barkley Street Suite 9 Overland Park KS 66212 913-381-9355

Patient Name: _____D.O.B:_____Date: _____

Informed Consent: 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• You authorized this office/provider to complete a consultation evaluation/examination & treat.

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), 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 our HIPPA document. We keep an electronic copy.

AUTHORIZATION FOR X-RAY RELEASE IF NEEDED• 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 & consent to x-rays if there is a determined need. You understand that if taken, it can take up to 24 hours to process & read x-rays. Kansas medical records law requires physician offices keep adult records for 10 years & minors age 19 whichever is longer. Kan. Admin. Regs. § 100-24-2 (a) (2008) Give 24 hours' notice to check out.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS• By signing below you have acknowledged that you are fully responsible for all services rendered. You agree to the following conditions, covenants and terms regarding the assignment of health benefits appearing in policy issued by your insurance company. By signing below you hereafter referred to as the "Patient", policy holder, understands and voluntarily agrees requests, orders and directs to assign all applicable health provisions pertaining to payments or benefits appearing in my insurance policy to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc with Rostberg Chiropractic & Acupuncture in consideration for treatment rendered by Anthony Rostberg, hereafter referred to as "Doctor" the sum due to the Doctor for treatment rendered as a result of illness/injuries the Patient. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an contract between you and your carrier, and that you may be required to pay some or all of the fees charged to your account here by assign. 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. The Patient gives the doctor the exclusive right to secure the funds assigned to the patient, including the right of securing counsel to represent the Doctor in collecting all sums due for treatment rendered. The Doctor and Patient hereby enter into this assignment of benefits freely and voluntarily and evidenced by the signature appearing below. The Patient and Doctor warrant that they have read this assignment of benefits and that each understand the legal effect of the same, and agree that each shall be bound by the covenants, terms and conditions appearing herein. You may be responsible for what your insurance doesn't pay or if you insurance changes or ends.

ACKNOWLEDGEMENT OF CONTACT: By signing below you understand that you can be contacted by text, email or phone.

ACKNOWLEDGEMENT OF CLINICAL SUMMARY REPORT (CCR) REGARDING EHR: By signing below you understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. I am asking this office to save them for me and not print them each visit. I understand that, given time, these reports are available to be printed or emailed to me for review.

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: _____ Cell phone: (___)_____-_____

Signature of Parent or Guardian: _____

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