FREEDOM WELLNESS CENTER

11128 Holmes Road * Kansas City, Missouri 64131 * 913.220.6514

Name ______________________ Home Phone ( ) ______

Street Address ______________________ Work Phone ( ) ______

City, State, Zip ______________________ Cell Phone ( ) ______

E-mail Address Marital Status:(circle one) S M D W S.O.

How do you prefer to be contacted (missed appt, reminders, etc.) Phone: hm / wk / cell ? Email? Both?

Birthdate/Age ______________________ Number of Children & Ages ______

Occupation ______________________ Employer's Name/Address ______

Guardian's Name ______________________ Social Security # and DOB ______

Name of Spouse or Nearest Relative and Phone Number? ______________________

Reason for consulting our office? ______________________

Whom may we Thank for referring you to our office? ______________________

Payment of Services by: Health Ins Self Pay Auto Ins Work Comp HSA/Flex Acct Other

Insurance Company: ______________________ Secondary Insurance Co? ______

Primary Insured's Name: ______________________

Primary Insured's DOB: ______________________ ***We ask for copies of insurance card(s) and ID

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT...

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first to, address the issues that brought you to this office, and second, to offer you the oportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

THE BEGINNING YEARS (TO AGE 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Did you have any childhood illnesses? Y / N Did you take/use any drugs? Y / N

Did you have any serious falls as a child? Y / N Did you have any surgery? Y / N

Did you play youth sports? Y / N Were you vaccinated? Y / N

Have you fallen/jumped from a height over three feet? (ie: crib, bunk bed, trees) Y / N

Were you involved in any accidents (car, bike, skateboard, sports, etc) as a child? Y / N

Was there any prolonged use of medicine such as antibiotics or an inhaler? Y / N

Did you suffer any other traumas? (physical or emotional) Y / N

As a child, were you under regular chiropractic care? Y / N

ADULT (18 TO PRESENT)

Do/did you smoke? Y / N Do/did you play any adult sports? Y / N

Do/did you drink alcohol? Y / N Do/did you participate in extreme sports? Y / N

On a scale of 1-10, describe your stress level:
(1=none / 10=extreme)

Occupational ____

Personal ____

On a scale of Poor, Good, Excellent describe your:

Diet ______

Exercise ______

Sleep ______

General Health ______

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MEDICAL/FAMILY HISTORY S = SELF M = MOTHER F = FATHER

S	M	F	Condition	S	M	F	Condition	S	M	F	Condition
☐	☐	☐	AIDS	☐	☐	☐	dislocated joints	☐	☐	☐	neck pain
☐	☐	☐	anemia	☐	☐	☐	epilepsy	☐	☐	☐	nervousness
☐	☐	☐	arthritis	☐	☐	☐	German measles	☐	☐	☐	numbness
☐	☐	☐	asthma	☐	☐	☐	headache	☐	☐	☐	polio
☐	☐	☐	back pain	☐	☐	☐	heart trouble	☐	☐	☐	poor circulation
☐	☐	☐	bladder trouble	☐	☐	☐	reproductive disorders	☐	☐	☐	hepatitis
☐	☐	☐	bone fracture	☐	☐	☐	high blood pressure	☐	☐	☐	rheumatic fever
☐	☐	☐	cancer	☐	☐	☐	HIV/ARC	☐	☐	☐	rheumatism
☐	☐	☐	chest pain	☐	☐	☐	kidney disorder	☐	☐	☐	scarlet fever
☐	☐	☐	concussion	☐	☐	☐	bowel control loss	☐	☐	☐	serious injury
☐	☐	☐	convulsions	☐	☐	☐	menstrual cramps	☐	☐	☐	sinus trouble
☐	☐	☐	diabetes	☐	☐	☐	multiple sclerosis	☐	☐	☐	tuberculosis
☐	☐	☐	indigestion/reflux	☐	☐	☐	muscular dystrophy	☐	☐	☐	venereal disease

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

☐	blurred vision	☐	face flushed	☐	loss of taste
☐	buzzing in ears	☐	fainting	☐	low resistance to colds
☐	cold feet	☐	fatigue	☐	muscle jerking
☐	cold hands	☐	fever	☐	numbness in fingers
☐	cold sweats	☐	head seems too heavy	☐	numbness in toes
☐	concentration loss	☐	headaches	☐	pins and needles in arms
☐	constipation	☐	insomnia	☐	pins and needles in legs
☐	depression	☐	light bothers eyes	☐	ringing in the ears
☐	diarrhea	☐	loss of balance	☐	shortness of breath
☐	dizziness	☐	loss of smell	☐	stiffness in neck

LIST ANY MEDICATIONS (and dosage) YOU ARE TAKING (including over ther counter)

____
____
____
____
____

LIST ANY ALLERGIES (to meds, food, environment) and REACTIONS

____
____
____

LIST ANY SURGERIES (with dates)

____
____
____

Y N Have you been treated by physician for any health condition in the last year?
Please describe________________________ Last Physical?______________

Y N Have you ever had a metal implant?

Y N Have you ever had a gunshot wound?

Y N Are you pregnant? if yes, due date________ if no, date of last menstrual period_______

What else would you like to discuss with the doctor today? ______________________
____
____
____

PATIENT SIGNATURE: ______________________________ DATE:______________

	Complaint # 1	Complaint # 2	Complaint # 3
Complaint (low back, neck, hips, midback, headaches, sinus trouble, intestinal problems, dizziness, nausea)			
Location (up/low neck/back, betw shldr. blades, one/both sides			
When did you first notice this?			
Has it happened before above date?			
Is it better/worse in a.m. or p.m.?			
Does the symptom travel to arms/legs/hands/feet?			
Does any position relieve symptom?			
Type of pain? (sharp, dull, achy, burn throb, numb, pins & needles)			
What makes it better? (list all) (bending, sitting, lifting, standing, walking, lying down, turning head, reaching, stretching)			
What makes it worse? (list all) (bending, reaching, straining at stool, coughing, sitting, turning head, lifting, twisting, sneezing, walking, lying down, standing)			
How many times a day/wk/mo/yr, or is it daily or constant?			
How long does it last? (min, hrs, days)			
Other doctors seen for this? (MD, Ortho, Chiro, Acup)			
What did they do? (Meds, Injections, Pain Ctr, P.T.)			
What have you tried? (ice, heat, rubs, massage, etc.)			
Medicines taken for this? Including over the counter?			
Does this affect/prevent daily activity?(y/n)			
Rate symptom on a scale 1-10 (10=worst) add how it affects/bothers you			
Anyone recommend medicines? (y/n)			
Anyone recommend surgery? (y/n)			
List traumas (even minor) including car, work, falls, injuries, etc.			
Why do you think your body is not getting better on its own?			
PATIENT NAME:	**PATIENT SIGNATURE:**	**DOB:**	**DATE:**

Chiropractic Informed Consent

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement. As a part of the analysis, examination, and treatment, you are consenting to the following procedures I deem necessary to evaluate and treat you. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

Spinal Manipulative Therapy	Muscle Strength Testing	Postural Analysis Testing
Range of Motion Testing	Orthopedic Testing	Basic Neurological
Palpation	Vital Signs	Radiographic Studies
Decompression	Hot/Cold Therapy	Muscle Stimulation/ Ultrasound

The following are the known risks:

Temporary soreness or increased symptoms/ pain is common, especially after the first few treatments.
Dizziness, nausea, flushing: these symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.
Bruising: Instrument adjustments or soft tissue manipulations may result in temporary soreness or bruising.
Fractures: When patients have underlying conditions that weaken the bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with such disease or condition and your treatment plan will be modified to minimize risk of fracture.
Disc herniation or prolapse: Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.
Stroke: A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary medical care visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. This increased occurrence of this type of stroke associated chiropractic and/or medical visits are most likely due to seeking care for symptoms before or during their stroke such as neck pain, headache, etc. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments.
Other: risks associated with chiropractic treatment include rare burns from the physiotherapy devices that produce heat or use of ice pack.

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
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers of remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Cindy Stoneking and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

____

Patient Name(print)   Signature (patient/parent/guardian)   Date

FREEDOM WELLNESS CENTER
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Freedom Wellness Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

<u>Disclosure of Your Health Care Information</u>

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

> "*On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Freedom Wellness Center.*"

> *"It is our policy to provide a substitute health care provider, authorized by Freedom Wellness Center to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

> "*As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Freedom Wellness Center for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.*"

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

<u>Public Health</u>
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with and reactions to medications, and reporting disease or infection exposure.

<u>Judicial and Administrative Proceedings</u>
We may disclose your health information in the course of any administrative or judicial proceeding.

<u>Law Enforcement</u>
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

<u>Deceased Persons</u>
We may disclose your health information to coroners or medical examiners.

<u>Organ Donation</u>
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

<u>Research</u>
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board

<u>Public Safety</u>
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

<u>Specialized Government Agencies</u>
We may disclose your health information for military, national security, prisoner and government benefits purposes.

<u>Marketing</u>
We may contact you for marketing purposes of fundraising purposes, as described below: (example)

“As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time or your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.”

“It is our practice to participate in charitable events to raise awareness, food donation, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Freedom Wellness Center sponsored fund-raising events.”

Change of Ownership
In the event that Freedom Wellness Center is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights:

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however that Freedom Wellness Center is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Freedom Wellness Center amend your protected health information. Please be advised, however, that Freedom Wellness Center is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Freedom Wellness Center.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Freedom Wellness Center reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Freedom Wellness Center is required by law to comply with this Notice.

Freedom Wellness Center is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Cindy Stoneking by calling this office at (913) 220-6514. You may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints
Complaints about your Privacy rights, or how Freedom Wellness Center has handled your health information should be directed to our privacy officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: OCRMail@hhs.gov

This notice is effective August 21, 2019.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Freedom Wellness Center with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

____
Patient’s Name (print)

____ ____________________
Patient’s Signature Date

____ ____________________
Authorized Facility Signature Date