INTAKE FORMS

www.mywichitachiro.com **3017 N. Cypress Suite B Wichita, KS 67226** **316-425-1911**

Patient Demographic

Name: _____ Date of Birth: ____-____-_____ Age: _____ Male / Female

Address: _____City: _____ State: _____ Zip_____

Social Security #:_____-_____-_____Email Address: _____

Home Phone: _____Mobile Phone: _____

Mobile Provider (for appt. text reminders Att, Verizon, T-Mobile, Sprint, etc.):_____Are you: Single Married Other

Employer: _____Occupation:_____

Emergency Contact: _____ Phone#:_____Relationship:_____

Whom may we thank for referring you to this office/ How did you hear about our office?

_____

Insurance Information Please complete this section regardless of your referral source. We are will verify your insurance coverage and explain your benefit information to you.

Is your condition due to an accident? Y / N Date of Accident: _____

Type of Accident: Auto Work Home

If this condition is due to an auto accident, we will require you to fill out our ACCIDENT HISTORY FORM

Insured (name on card):_____Date of Birth: _____ Relationship to Patient: _____

Insurance Company: _____ Policy# or SSN# of insured: _____

ASSIGNMENT and RELEASE:

I certify that I, and/ or my dependent(s), have insurance coverage with ,stated above, insurance company and directly assign to OPTIMAL WELLNESS, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions.

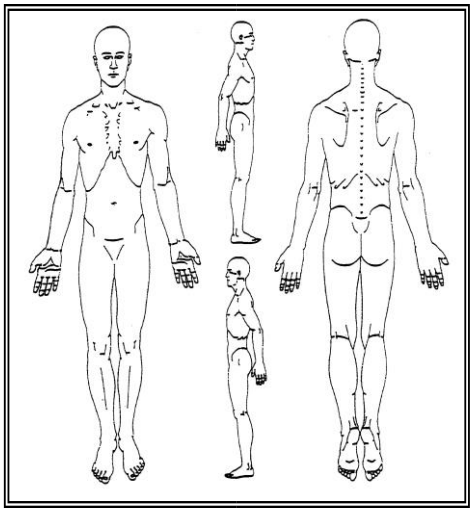
Notice of Privacy Practice (HIPPA)

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. If you would like a more detailed explanation, one will be provided to you. Once you have read and agree to this notice please sign below.

_____ _____

Patient or Authorized Person's Signature Date Completed

Medical History



Please mark the areas on the diagram with the following letters to describe your symptoms to the doctor:

Radiating Burning Dull Aching Numbness Sharp/Stabbing Tingling

Using the pain scale below circle the pain level you experience when your problem is at its VERY worst.

0 1 2 3 4 5 6 7 8 9 10

No pain Moderate Pain Excruciating Pain

When did this problem(s) begin? _____ Have you seen any doctors for this problem? _____

What tests have you already had for this problem? X-RAYS MRI Myelogram EMG/NCV NONE

OTHER: _____

How often do you experience your problem (circle one)?

Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Intermittent (0-25%)

What makes your problem WORSE (circle all that apply)? Sitting Standing Walking Bending Lifting Twisting Reaching Driving Sleeping Sneeze/Cough Computer Work Exercise

What posture/position/repetitive movement does your job require most of the day?

_____

Please list any conditions you have been diagnosed with/have been treated over the course of your life:

_____

_____

Please list any surgeries you have had over the course of your life:

_____

_____

Are you allergic to any medications? Y N If yes, please list: _____

List any medications, herbs, or supplements you are taking and reason for usage:

_____

_____

_____

On a sale of 1-10 (1-worst 10-best) rate how well you think you are doing with the following:

Exercise_____ Sleep_____ Diet_____ Ability to Manage Stress_____ Water Intake_____ Energy Level_____

Family History

Mother: Living or Deceased List Any Medical Conditions/Problems:_____

Father: Living or Deceased List Any Medical Conditions/Problems:_____

Circle any medical conditions common in your family:

Cancer Diabetes Heart Disease High Blood Pressure Stroke Arthritis Scoliosis Thyroid Disease Osteoporosis Other:_____

Are there any other concerns the doctor should be aware of?

_____

_____

Medical Symptoms Questionnaire

Patient Name: _____ Date:_____

Rate each of the following symptoms based on your typical health profile for the past 7 days.

0- Never or almost never have the symptom
1- Occasionally have it, effect is not severe
2- Occasionally have it, effect is severe
3- Frequently have it, effect is not severe
4- Frequently have it, effect is severe

HEAD _____Headaches _____Faintness _____Dizziness _____Insomnia **Total_____**	**ENERGY/ACTIVITY** _____Fatigue, Sluggishness _____Apathy, Lethargy _____Hyperactivity _____Restlessness **Total_____**	**LUNGS** _____Chest Congestion _____Asthma, Bronchitis _____Shortness of Breath _____Difficulty Breathing **Total_____**
EYES _____Watery or Itchy Eyes _____Swollen, Reddened or Sticky Eyelids _____Bags or Dark Circles Under Eyes _____Blurred or Tunnel Vision (does not include near or far-sighted) **Total_____**	**WEIGHT** _____Binge Eating/Drinking _____Craving Certain Foods _____Excessive Weight _____Compulsive Eating _____Water Retention _____Underweight **Total_____**	**HEART** _____Irregular or Skipped Heartbeat _____Rapid or Pounding Heartbeat _____Chest Pain **Total_____**
EARS _____Itchy Ears _____Earaches, Ear Infections _____Drainage from Ear _____Ringing in Ears, Hearing Loss **Total_____**	**EMOTIONS** _____Mood Swings _____Anxiety, Fear, Nervousness _____Anger, Irritability, Aggressiveness _____Depression **Total_____**	**DIGESTIVE TRACT** _____Nausea, Vomiting _____Diarrhea _____Constipation _____Bloated Feeling _____Belching, Passing Gas _____Heartburn _____Intestinal/Stomach Pain **Total_____**
NOSE _____Stuffy Nose _____Sinus Problems _____Hay Fever _____Sneezing Attacks _____Excessive Mucus Formation **Total_____**	**MIND** _____Poor Memory _____Confusion, Poor Comprehension _____Poor Concentration _____Poor Physical Condition _____Difficulty in Making Decisions _____Stuttering or Stammering _____Slurred Speech _____Learning Disabilities **Total_____**	**JOINTS/MUSCLE** _____Pain or Aches in Joints _____Arthritis _____Stiffness or Limited Movement _____Pain or Aches in Muscles _____Feeling of Weakness or Tiredness **Total_____**
MOUTH/THROAT _____Chronic Coughing _____Gagging, Frequent Need to Clear Throat _____Sore Throat, Hoarseness, Loss of Voice _____Swollen or Discolored Tongue, Gums/Lips _____Canker Sores **Total_____**	**OTHER** _____Frequent Illness _____Frequent or Urgent Urination _____Genital Itch or Discharge **Total_____**	**SKIN** _____Acne _____Hives, Rashes, Dry Skin _____Hair Loss _____Flushing, Hot Flashes _____Excessive Sweating **Total_____**
	GRAND TOTAL:_____	

INFORMED CONSENT

Regarding X-Rays/Imaging Studies:
By my signature below, I hereby give my consent to OPTIMAL WELLNESS and its representatives to take X-RAYS as deemed appropriate by the examining Doctor of Chiropractic. I have conveyed my understanding of the risks associated with exposure to X-RAYS.

FEMALES- I declare to the best of my knowledge that I AM NOT PREGNANT.
I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child.

_____ _____

Patient or Authorized Person's Signature Date Completed

Regarding: Chiropractic Adjustments, Modalities, and Therapeutic Procedures
I have been advised that chiropractic care, like all forms of health care, holds certain risks. While risks are most often very minimal, in rare cases, complications such as, but not limited to, sprain/strain injuries, irritation of a disc condition, fractures, strokes (CVA), and dislocations.

I further understand that such chiropractic services may be performed by OPTIMAL WELLNESS and/or other licensed Doctors of Chiropractic who may treat me now or in the future at this office. I have had the opportunity to discuss with DR. NATHAN HANDS and/or other office personnel the nature and purpose of chiropractic adjustments and other procedures. Further, I wish to rely on the doctor(s) to exercise judgement during the course of treatment, which the doctor(s) feels are in my best interest at the time, based upon known facts, I have read, or have been read to me.

I hereby CONSENT to treatment by any means, methods, and/or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____

Patient or Authorized Person's Signature Date Completed