BRACKEEN CHIROPRACTIC WELLNESS & REHAB

320 N. Rock Road, Suite 300
Derby, KS 67037
Phone (316) 789-8100
Fax (316) 789-9400

Patient Information

PERSONAL INFORMATION

Date_____

Name_____ **Preferred Name (if different)**_____
First Name Middle Initial Last Name

Address_____ **City**_____**State**_____**Zip**_____

Home Phone_____ **Cell Phone**_____ **Work Phone**_____

Date of Birth (mm/dd/yyyy)_____ **Social Security #**_____

Email Address_____ **Referral Source**_____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Employment Status: Employed ____ Retired ____ Disabled ____ Part Time Student ____ Full Time Student _____

Employer _____ **Occupation** _____

Emergency Contact Person _____ **Phone** _____

INSURANCE INFORMATION

Policy Holder's Name_____ **Date of Birth**_____

Policy Holder's Address_____**City**_____**State**_____**Zip**_____

Name of Insurance_____

ID Number_____ **Group Number**_____

HISTORY OF PRESENT CONDITION(S)

Chief Complaint(s)_____

Is This Due to an Injury: Yes___ No___ **Type of Injury: Auto_____ Work_____ Personal_____**

Date of Injury:_____ **Days Lost From Work:_____**

Has Your Pain Become Worse: Yes___ No___

How Frequent is Your Condition: Constant___ Daily___ Intermittent___ Night Time___ Morning Time___

Describe Your Pain: Sharp___ Dull___ Numbness___ Tingling___ Aching___ Burning___ Stabbing___ Other___

Does Your Pain Radiate: Yes___ No___ If Yes, From Where to Where:_____

What Makes Your Pain Worse: Standing___ Sitting___ Lying___ Bending___ Lifting___ Twisting___ Other___

Have You Tried Anything to Relieve the Pain: Yes___ No___ If Yes, Please Describe:_____

_____

PLEASE CIRCLE DEGREE OF PAIN IN THE REGION YOU ARE HAVING DISCOMFORT. MARK THE AREAS OF PAIN ON THE FIGURES BELOW.

Neck Pain

0 1 2 3 4 5 6 7 8 9 10

Shoulder, Arm Pain

0 1 2 3 4 5 6 7 8 9 10

Mid Back Pain

0 1 2 3 4 5 6 7 8 9 10

Low Back Pain

0 1 2 3 4 5 6 7 8 9 10

Hip, Leg Pain

0 1 2 3 4 5 6 7 8 9 10

Foot, Ankle Pain

0 1 2 3 4 5 6 7 8 9 10

Other

0 1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

FEMALES: Are You Pregnant: Yes___ No___ Uncertain___ If Yes, How Many Weeks Pregnant:_____

Have You Had Any Broken Bones, Fractures, or Dislocations: Yes___ No___

List Broken Bones, Fractures, or Dislocations:

_____ _____

_____ _____

Have You Had Any Surgeries: Yes___ No___

List Surgeries You Have Had:

_____ _____

_____ _____

Please Mark the Drugs You are Now Taking: Pain Killers___ Muscle Relaxers___ Anti-Inflammatory___ Insulin____

Blood Pressure Medication___ Nerve Medication___ Anti-Depressants___ Other_____

Do You Have Allergies: Yes___ No___ If Yes, What Type:_____

List Any Other Health Conditions:_____

CONSENT TO TREAT

I hereby authorize the Doctor to examine and treat my condition as he/she seems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. I intend for this consent to cover the entire course of treatment my present or any future condition(s) for which I seek treatment.

HIPAA

Brackeen Chiropractic/Shaw Chiropractic will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

FINANCIAL RESPONSIBILITY

I authorize payment of insurance benefits directly to Brackeen Chiropractic/Shaw Chiropractic.
Regardless of insurance coverage, I understand that I am responsible for all costs of chiropractic care.
I understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient's Signature_____ Date_____
Guardian or
Legal Representative Signature_____ Date_____