

Name: _____ Patient #: _____ Age: _____ Date: _____

Address: _____
Residence and mailing City State Zip Code

Home Telephone () _____ Work Phone () _____

Email Address _____ Male _____ Female _____

Social Security # _____ Driver's Lic.# _____ Birthdate _____

Occupation/Employer's Name and address _____

Single _____ Married _____ Divorced _____ Widowed _____ Spouse's Occupation/Employer _____

No. of children: _____ (In Canada) Health Card# _____ Version Code: _____

Reason for consulting our office? _____

Who may we Thank for referring you to our office? _____

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 opportunity 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.

YOUR CHILDHOOD YEARS

YES NO UNSURE

YES NO UNSURE

Did you have any childhood illnesses?

Did you have any serious falls as a child?

Did you play youth sports?

Did you take / use any drugs?

Did you have any surgery?

Have you fallen / jumped from a height over three feet? (i.e. crib, bunk bed, trees)

Were you involved in any car accidents as a child?

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

Did you suffer any other traumas (physical or emotional)

Were you vaccinated?

As a child, were you under regular Chiropractic care?

COMMENTS: _____

ADULT - (18 TO PRESENT)

YES NO

YES NO

Do / did you smoke?

Do / did you drink alcohol?

Have you been in any accidents?

Have you had any surgery?

Do / did you play any adult sports?

Do / did you participate in extreme sports?

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 _____

Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here ____ **“Wish to have Chiropractic Wellness Services”** and skip to **“Family Health Profile.”** Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

If you are experiencing pain, is it...

- Sharp Dull Comes and goes Travels Constant

Since the problem started, it is... About the same Getting better Getting worse

What makes it worse: _____

Yes, it interferes with: Work Sleep Walking Sitting Hobbies Leisure

Other Doctors seen for this problem (please list)

- Chiropractor _____
 Medical Doctor _____
 Other _____

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Pins and Needles in arms | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Problem Urinating | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Ulcers |

List any medications you are taking _____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____
 Spouse _____
 Mother _____
 Father _____
 Brothers _____
 Sisters _____
 Others _____

Have you ever:

- Bought bottled water: YES NO
 Belonged to a health club: YES NO
 Consumed vitamins or supplements: YES NO

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Signature

Date



Innate Family Chiropractic
4020 Baltimore Ave
Kansas City, MO 64111
816-561-1500
www.innatefamilychiropractic.com

Welcome to our wellness center,

Today we are here to discover your goals and priorities as it relates to your health and wellness. Your answers will help us determine how we can best help you.

Let's get started...

On a scale of 1 – 10, rate the importance for you to achieve the following:

1 = not important 10 = necessary

Get fit	1	2	3	4	5	6	7	8	9	10
Eat better	1	2	3	4	5	6	7	8	9	10
Reduce stress	1	2	3	4	5	6	7	8	9	10
Stop smoking	1	2	3	4	5	6	7	8	9	10
Reduce pain	1	2	3	4	5	6	7	8	9	10
Increase my mobility	1	2	3	4	5	6	7	8	9	10
Improve my posture	1	2	3	4	5	6	7	8	9	10
Improve my sleep	1	2	3	4	5	6	7	8	9	10
Learn about wellness	1	2	3	4	5	6	7	8	9	10
Improve my health	1	2	3	4	5	6	7	8	9	10
Learn about wellness products that are right for me	1	2	3	4	5	6	7	8	9	10
Other _____	1	2	3	4	5	6	7	8	9	10

Which of the above would you say is the most important goal for you to achieve and why?

Have you ever attempted to accomplish this goal in the past? Yes No

If yes, what happened and what prevented you from maintaining your results? _____

Do you have any questions or comments? _____

Remember: your health is your greatest asset, the more of it you have the healthier you are.

We look forward to helping you Discover Wellness.

Consent to Care

When a person seeks Chiropractic care and we accept a person for care it is essential for both to be working towards the same goals. Chiropractic has a specific goal to remove subluxation (nerve interference) from the body. Removing subluxation through adjustments allows the body to function at its optimal potential. Through your care we will provide wellness education on the reduction of the 3 major stressors: Physical stress, Chemical stress, and Emotional Stress. It is important that each person understand the objective and the method that will be used to attain it. This will prevent confusion.

We do not offer to diagnose or treat any disease. Our focus in this office is the vertebral subluxation and promotion of wellness through lifestyle education. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnosis or treatment for those findings we recommend that you seek another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR PRACTICE OBJECTIVE is to locate, analyze and correct subluxation through specific adjustments while promoting wellness through lifestyle changes and education.

I, _____ have read and fully understand the above statements.
(Print Name)

All questions regarding the chiropractor's objective to my care in her office have been answered to my complete satisfaction. I therefore accept care on this basis.

Signature

Date

X-RAY QUESTIONNAIRE: FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

There is a possibility that I may be pregnant at this time.

Yes, I am definitely pregnant.

No, I am definitely not pregnant at this time.

I request x-ray films not be taken because _____ Date of last menstrual period _____

Signature

Date

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I _____ being the parent or legal guardian of _____

Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature

Date

Innate Family Chiropractic
4020 Baltimore Ave.
Kansas City, MO 64111
816-561-1500

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient

Date

Office Financial Policy

●At this time Innate Family Chiropractic does not participate with 3rd party payers. It is the policy of this office that visits will be paid at time of service or be pre-paid through one of our payment plans. **We want you to benefit from your insurance. We will provide you with the paperwork required by your insurance company in order to receive reimbursement.** The form will provide all necessary information that your insurance company will need in order to send your reimbursement.

●**We encourage all patients with insurance policy's that cover chiropractic care to call for information about their benefits. We can also validate your insurance and help you understand your policy.** With deductibles and co-pays increasing each year our office provides affordable care to our patients.

●**For all patients, you have payment options.** You can choose to pay visit by visit or pre-pay for your schedule of care. Pre-paid plans come with a bookkeeping savings. All payment options will be discussed during your Report of Findings, on your second visit, after a recommendation of care has been given.

I have read and agree to the terms described above.

Signature

Date