DOPPS Chiropractic DERBY

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Derby, KS 67037

CONFIDENTIAL PATIENT HEALTH HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: *(First MI Last)* _____ **Preferred Name:** _____

Address: _____ **Apt:** ____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

Email: _____ **Gender:** M / F **Marital Status**: S / M / D / W **DOB:** _____

Job Status: Not Employed / Employed / Part-time Student / Full-time Student

Occupation: _____ **Employer:** _____

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

EMERGENCY CONTACT INFORMATION

Name: _____

Phone: _____

Relationship: Child / Parent / Spouse / Other: _____

Primary Care Physician: _____

Doctor's Office: _____

May we send health updates to this physician? Y / N

FINANCIAL INFORMATION

Is today's visit the result of an accident? No / Auto / Work / Other _____

Will we be working with Health Insurance? No / Yes *(Complete Details Below)*

Primary Insurance: _____

Policy Holder: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Secondary Insurance: _____

Policy Holder: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

I authorize payment of medical benefits to Dopps Chiropractic Derby for any services provided to me or my dependents. I understand I am financially responsible for any amount not covered by my insurance.

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient or Guardian Signature_____ Date _____

HISTORY OF PRESENT ILLNESS

Major Complaint _____

Secondary Complaint(s) _____

When did this start? _____

How did this start? _____

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
- ❑ Numb
- ❑ Tingling
- ❑ Stiff
- ❑ Other: _____

Does it radiate?
- ❑ No
- ❑ Yes _____

Improves with:
- ❑ Nothing
- ❑ Ice
- ❑ Heat
- ❑ Movement
- ❑ Stretching
- ❑ OTC Medications: _____
- ❑ Rx Medications: _____
- ❑ Other: _____

Worsens with:
- ❑ Sitting
- ❑ Standing
- ❑ Walking
- ❑ Lying Down
- ❑ Overuse
- ❑ Lifting
- ❑ Movement
- ❑ Changing Positions
- ❑ Other: _____

Previous Treatment
- ❑ None
- ❑ Chiropractor _____
- ❑ Medical Doctor _____
- ❑ Physical Therapy _____
- ❑ ER _____

Previous Diagnostic Testing (Circle one)
X-rays – MRI – CT – None

How is it affecting your life?
- ❑ It's difficult or I am unable to work.
- ❑ It's hard or I am unable to do the things I love.
- ❑ It's hard to play with my children.
- ❑ It's hard or impossible to play sports or recreational activities.
- ❑ My home life is diminished.
- ❑ My relationships are suffering.
- ❑ I'm having difficulty sleeping.
- ❑ It's difficult to move around.

MEDICAL HISTORY

Have you *ever* had any of the following? *(Please select all that apply.)*

Illnesses:
- ❑ Asthma
- ❑ Autoimmune Disorder *(Type)* _____
- ❑ Blood Clots
- ❑ Cancer *(Type)* _____
- ❑ CVA/ TIA (Stroke)
- ❑ Diabetes
- ❑ Migraine Headaches
- ❑ Osteoporosis
- ❑ Other: _____

***Women:** *Are you pregnant?*
- ❑ No *Last Menstrual Period:* ___/___/___
- ❑ Yes *Due Date:* ___/___/___

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
  - o Shoulder – L / R _____
  - o Elbow/Forearm – L / R _____
  - o Wrist/Hand – L / R _____
  - o Hip – L / R _____
  - o Knee – L / R _____
  - o Ankle/Foot – L / R _____
- ❑ Spinal
  - o Neck: _____
  - o Back: _____
- ❑ Other: _____

Prescription Medications: ❑ None _____

Allergies to Medications: ❑ No known drug allergies _____

FAMILY HISTORY

Does anyone in your IMMEDIATE family have a history of:

- ❑ Aneurysm _____
- ❑ CVA (Stroke) _____
- ❑ Cancer _____
- ❑ Diabetes _____
- ❑ Heart Disease _____
- ❑ Hypertension _____

REVIEW OF SYSTEMS

Are you *currently* experiencing any of these symptoms? *(Please select all that apply.)*

Constitutional: *(General)*
- ❑ Fever
- ❑ Fatigue
- ❑ *None in this Category*

Musculoskeletal:
- ❑ Joint Pain/Stiffness/Swelling
- ❑ Muscle Pain/Stiffness/Spasms
- ❑ *None in this Category*

Neurological:
- ❑ Dizziness or Lightheaded
- ❑ Convulsions or Seizures
- ❑ Tremors
- ❑ *None in this Category*

Psychiatric: (Mind/Stress)
- ❑ Nervousness/Anxiety
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ *None in this Category*

Genitourinary:
- ❑ Frequent or Painful Urination
- ❑ Blood in Urine
- ❑ Incontinence or Bed Wetting
- ❑ Painful or Irregular Periods
- ❑ *None in this Category*

Gastrointestinal:
- ❑ Loss of Appetite
- ❑ Blood in Stool or Black Stool
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Frequent Diarrhea
- ❑ Constipation
- ❑ *None in this Category*

Cardiovascular & Heart:
- ❑ Chest Pains/Tightness
- ❑ Rapid or Heartbeat Changes
- ❑ Swelling of Hands, Ankles, or Feet
- ❑ *None in this Category*

Respiratory:
- ❑ Difficulty Breathing
- ❑ Cough
- ❑ *None in this Category*

Eyes & Vision:
- ❑ Eye Pain
- ❑ Blurred or Double Vision
- ❑ Sensitivity to Light
- ❑ *None in this Category*

Endocrine:
- ❑ Infertility
- ❑ Recent Weight Change
- ❑ Eating Disorder
- ❑ *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
- ❑ *None in this Category*

Hematologic & Lymphatic:
- ❑ Excessive Thirst or Urination
- ❑ Cold Extremities
- ❑ Swollen Glands
- ❑ *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
- ❑ *None in this Category*

Allergic/Immunologic:
- ❑ Food Allergies
- ❑ Environmental Allergies
- ❑ *None in this Category*

Print Name *(First MI Last)*_____ Date _____

I have answered these questions to the best of my knowledge and certify them to be true and correct and I hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

AUTHORIZATION AND RELEASE: (please read and sign)

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also 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. _____**Initials**

I authorize treatment by Dopps Chiropractic Derby, LLC. I understand that I will be treated for my condition by a licensed Chiropractor in this office. I understand that there are certain inherent risks to any healthcare procedure. It is possible that complications can arise as a result of my treatment. I understand that my Doctor will make every reasonable effort during my examination to screen for contradictions, however, it is my responsibility to inform my Doctor about any conditions, not otherwise discussed. I further understand that I am responsible for keeping my scheduled appointments and that if I fail to do so it may be detrimental to the healing process. I understand that I am responsible for completely disclosing information regarding the status of my health or condition to the doctor and staff at Dopps Chiropractic Derby, LLC. _____ **Initials**

I understand and agree that this chiropractic office will be using my Patient Health Information for the purpose of treatment, payment, healthcare operation and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. If there is anyone you do not want to receive your medical records, please inform our office. _____ **Initials**

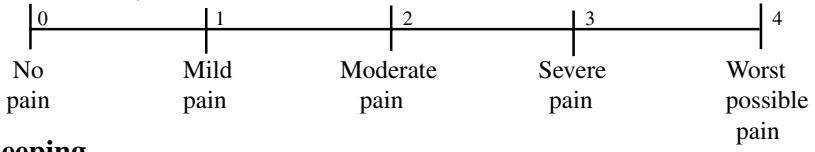
Patient or Guardian Signature_____ Date _____

Functional Rating Index

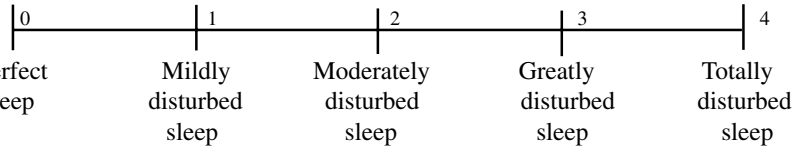
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

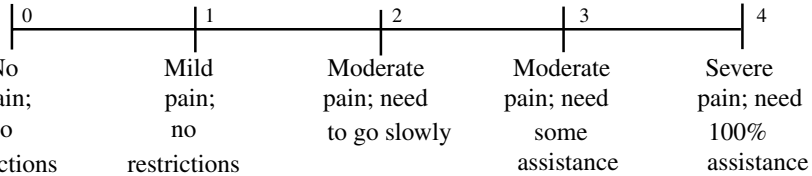
1. Pain Intensity



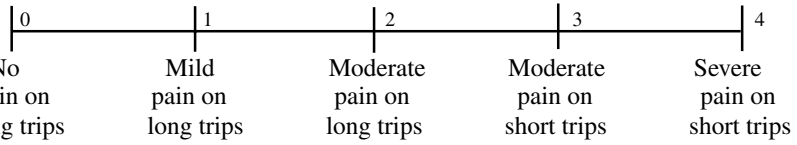
2. Sleeping



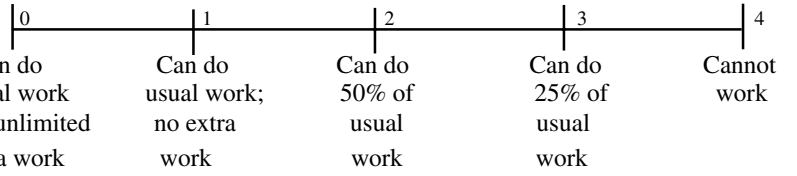
3. Personal Care (washing, dressing, etc.)



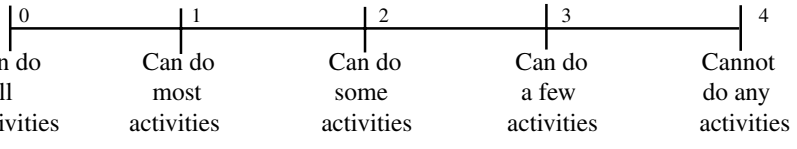
4. Travel (driving, etc.)



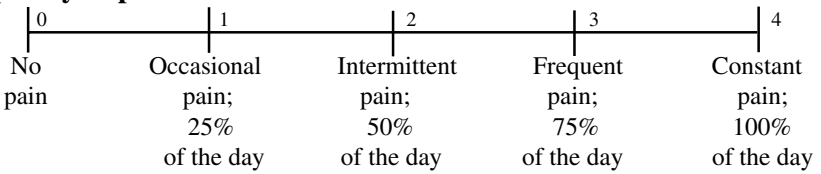
5. Work



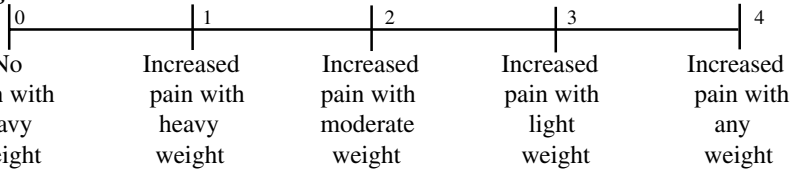
6. Recreation



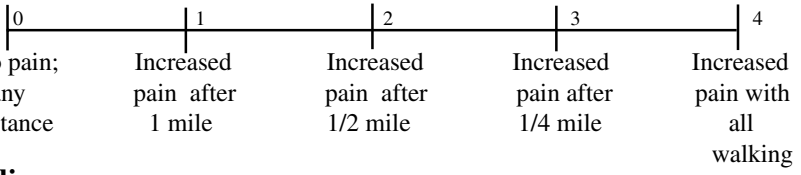
7. Frequency of pain



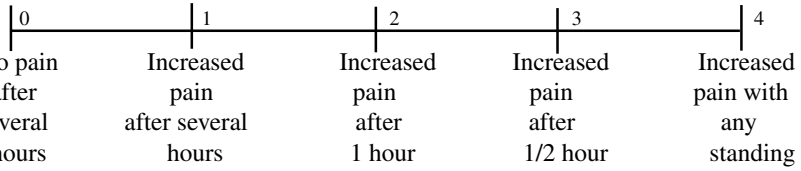
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date