ROLING
CHIROPRACTIC & WELLNESS

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____
First Middle Last

Address: _____ SS#: _____
Street City State Zip
Gender: Male Female

Phone Number: _____ Email: _____
Occupation/Employer: _____

How did you hear about us? (Check one): ☐ Facebook ☐Instagram ☐Search engine ☐Friends/Family ☐Other:

Preferred Appointment Reminders: (Check one): ☐Phone ☐Text ☐Email

Primary Language: _____ Ethnicity: _____

Spouse/Guardian: _____ Phone: _____
First Middle Last

EMERGENCY – Nearest relative or friend not living with you: _____
Relation: _____ Phone Number: _____

PATIENT MESSAGING CONSENT

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications via an automated outreach and messaging system. I also authorize my healthcare provider to disclose to third parties who may intercept these messages (individuals you have provided with access to your digital device or email accounts), limited protected health information (PHI) regarding my healthcare events. I consent to the receiving of multiple messages per day from the automated outreach and messaging system, when necessary.

_____ _____
Patient Name Date

_____
Patient Signature

(913) 912-7007
Rolingchiropractic@gmail.com
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MEDICAL AND HEALTH HISTORY

Your personal health history is a vital part of your visit with us today, please complete the following information.

MAIN PROBLEM
What is the reason for your visit today?
What happened RECENTLY to make you decide to seek help now?

Date of last physical exam: _____ Name of Provider: _____

Medical Conditions diagnosed by a doctor: _____

Surgeries: _____

Other hospitalizations: _____

SYMPTOMS - *Please mark if you have now*									
Fever	Yes	☐	No	☐	Difficulty starting/stopping stream	Yes	☐	No	☐
Unexplained weight loss	Yes	☐	No	☐	Joint pain	Yes	☐	No	✔
Chills	Yes	☐	No	☐	Black stools	Yes	☐	No	☐
Changes in vision	Yes	☐	No	☐	Foot swelling	Yes	☐	No	☐
Difficulty swallowing	Yes	☐	No	☐	Depression	Yes	☐	No	☐
Problems with hearing or smell	Yes	☐	No	☐	Anxiety	Yes	☐	No	☐
Chest pain	Yes	☐	No	☐	Panic attacks	Yes	☐	No	☐
Racing heart	Yes	☐	No	☐	Excessive thirst	Yes	☐	No	☐
Palpitations	Yes	☐	No	☐	Frequent urination	Yes	☐	No	☐
Cough	Yes	☐	No	☐	Swelling in the neck	Yes	☐	No	☐
Wheezing	Yes	☐	No	☐	Swollen glands	Yes	☐	No	☐
Shortness of breath	Yes	☐	No	☐	Easy bleeding	Yes	☐	No	☐
Stomach pains	Yes	☐	No	☐	Poor healing	Yes	☐	No	☐
Blood in stool	Yes	☐	No	☐	Frequent headaches or current headache	Yes	☐	No	☐
Constipation	Yes	☐	No	☐	Loss of consciousness	Yes	☐	No	☐
Blood in urine	Yes	☐	No	☐	Numbness/pins and needles sensation	Yes	☐	No	☐
Burning during urination	Yes	☐	No	☐	Worrisome or changing skin lesions	Yes	☐	No	☐
Skin rashes	Yes	☐	No	☐	Hair Loss	Yes	☐	No	☐
Dizziness	Yes	☐	No	☐	Other joint/bone concerns	Yes	☐	No	☐

CURRENT MEDICATIONS *(Include - all Prescriptions and over the counter including Vitamins)*

Name of Medication	Dose	Frequency

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Allergies to medications	Reaction

Please use the back side of this paper if more room is needed. ***Continued on back? YES☐ No☐***

PERSONAL HISTORY - Do you have any history of the following conditions?					If YES to any, please Explain
Joint replacements/pins/screws/plates	Yes	☐	No	☐	
Thyroid Problems	Yes	☐	No	☐	
Seizures	Yes	☐	No	☐	
Stroke	Yes	☐	No	☐	
Asthma	Yes	☐	No	☐	
C.O.P.D.	Yes	☐	No	☐	
Sleep Apnea	Yes	☐	No	☐	
Coronary Artery Disease	Yes	☐	No	☐	
Congestive Heart Failure	Yes	☐	No	☐	
Chest Pain	Yes	☐	No	☐	
High Blood Pressure	Yes	☐	No	☐	
Elevated Cholesterol	Yes	☐	No	☐	
Heart Attack	Yes	☐	No	☐	
Implantable Devices	Yes	☐	No	☐	
Cardiac Arrhythmia	Yes	☐	No	☐	
Rheumatic Fever	Yes	☐	No	☐	
Diabetes	Yes	☐	No	☐	
Liver Problems	Yes	☐	No	☐	
Stomach Problems	Yes	☐	No	☐	
Irritable Bowel Syndrome	Yes	☐	No	☐	
Allergy/Sensitivity	Yes	☐	No	☐	
Reflux (G.E.R.D.)	Yes	☐	No	☐	
Kidney Problems	Yes	☐	No	☐	
Incontinence of Urine	Yes	☐	No	☐	
Genitourinary Problems	Yes	☐	No	☐	
Osteoporosis	Yes	☐	No	☐	
Back or Neck Problems	Yes	☐	No	☐	
Arthritis	Yes	☐	No	☐	
Skin Problems	Yes	☐	No	☐	
Anemia	Yes	☐	No	☐	
Blood Disorder	Yes	☐	No	☐	
M.R.S.A. / V.R.E.	Yes	☐	No	☐	
Tuberculosis	Yes	☐	No	☐	
difficile	Yes	☐	No	☐	

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Hepatitis	Yes	☐	No	☐	
HIV or AIDS	Yes	☐	No	☐	
Depression	Yes	☐	No	☐	
Anxiety	Yes	☐	No	☐	
Eating Disorder	Yes	☐	No	☐	
Menstrual Problems	Yes	☐	No	☐	
Abnormal Pap Smear	Yes	☐	No	☐	
Cancer	Yes	☐	No	☐	
Drug or Alcohol Addiction	Yes	☐	No	☐	
Other Medical Problems	Yes	☐	No	☐	
SOCIAL HISTORY					
Do you feel safe at home	Yes	☐	No	☐	
Do you want to discuss abuse	Yes	☐	No	☐	
Is someone threatening you	Yes	☐	No	☐	
Do you use recreational drugs?	Yes	☐	No	☐	If Yes, what and how often?
Do you smoke?	Yes	☐	No	☐	If Yes, how many per day?
Do you drink?	Yes	☐	No	☐	If Yes, how much?
Do you exercise regularly?	Yes	☐	No	☐	If Yes how often?
Are you pregnant?	Yes	☐	No	☐	**Are you Employed?** ☐Yes ☐No If So Where?
Is your Mother Deceased?	Yes	☐	No	☐	**Marital Status** ☐Married ☐Single ☐Divorced ☐Other
Is your Father Deceased?	Yes	☐	No	☐	**Highest Level of Education** ☐College ☐High School ☐GED ☐Other

FAMILY HISTORY *(If yes to any, please list relationship)* If unknown, please check here: ☐

		Relationship				Relationship	
Aneurysms	☐			Diabetes	☐		
Bleeding tendencies	☐			Alcohol dependence	☐		
Breast cancer	☐			Drug abuse	☐		
Colo-Rectal cancer	☐			Heart problems	☐		
Ovarian cancer	☐			Hypertension	☐		
Pancreatic cancer	☐			Stroke	☐		
Other cancers	☐			Mental illness	☐		

Please list any other questions or concerns you have:

_____

I have answered the above questions to the best of my knowledge

_____ _____

Patient / Legal Guardian Signature *Date*

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Sign only after you understand and agree to the above.

_____
Printed name of Patient

_____ _____
Signature of Patient *Date*

_____ _____
Signature of Representative *Date*
(if patient is a minor or is handicapped)

_____ _____
Witness to Patient's Signature *Date*

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ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____
Printed name of Patient

_____ _____
Signature of Patient/Representative *Date*

For Office

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**

Staff **Date:**

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