key dynamics
CHIROPRACTIC

DEMOGRAPHICS

Patient name_____
Last First M.I.
Male ☐ Female ☐ I would prefer to be called_____
Date of birth ___/___/___ Age_____ SS#_____ Have you seen a Chiropractor before?_____
Street Address_____
City_____ State_____ Zip Code_____
Home Phone_____ Work Phone_____ Cell Phone_____
Email Address_____
Occupation_____
Employer_____ How long?_____
Employer Address_____
Status: Minor Single Married Divorced Separated Widowed
Spouse's Name_____ Number of Children?_____
Who may we thank for your referral?_____
Primary Care Physician_____

HEALTH HISTORY

Please list all medications you are currently taking (prescribed or over the counter):

_____

_____

_____

Place a mark on "Yes" or "No" to indicate if you've had any of the follow:

AIDS/HIV	Yes ☐	No ☐	Gout	Yes ☐	No ☐	Pinched Nerve	Yes ☐	No ☐
Allergies	Yes ☐	No ☐	Heart Disease	Yes ☐	No ☐	Prostate Issues	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐	Rheum. Arthritis	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐	Hernia	Yes ☐	No ☐	Sinus Condition	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Herniated Disk	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Backaches	Yes ☐	No ☐	Migraine Headache	Yes ☐	No ☐	Thyroid Issues	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Other Headache	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Concussion	Yes ☐	No ☐	Multiple Sclerosis	Yes ☐	No ☐	Tumors	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Muscular Dystrophy	Yes ☐	No ☐	Ulcers	Yes ☐	No ☐
Digestive Disorders	Yes ☐	No ☐	Neuritis	Yes ☐	No ☐	Other:		
Dizziness/Vertigo	Yes ☐	No ☐	Numbness	Yes ☐	No ☐	_____		
Emphysema	Yes ☐	No ☐	Osteoporosis	Yes ☐	No ☐	_____		
Epilepsy	Yes ☐	No ☐	Pacemaker	Yes ☐	No ☐	_____		
Fractures	Yes ☐	No ☐	Parkinson's Disease	Yes ☐	No ☐	_____		

Exercise
☐ None
☐ Moderate
☐ Daily
☐ Heavy

Work Activity
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

Habits
☐ Smoking
☐ Alcohol
☐ Coffee/Caffeine Drinks
☐ High Stress

Packs/Day_____
Drinks/Week_____
Cups/Day_____
Reason:_____

Are you pregnant? Yes ☐ No☐ Due Date: _____

Please describe any injuries or surgeries you have had: _____

_____

Dr. Steven Reece & Dr. Amanda Buchanan
153 W 151st St, STE 150, Olathe, KS 66061 913.390.9355

CONCERNS

What is your major complaint or concern?_____

_____

When did your symptoms appear?_____

Are your symptoms: ☐ getting worse? ☐ getting better?

What treatment have you already received for your condition?

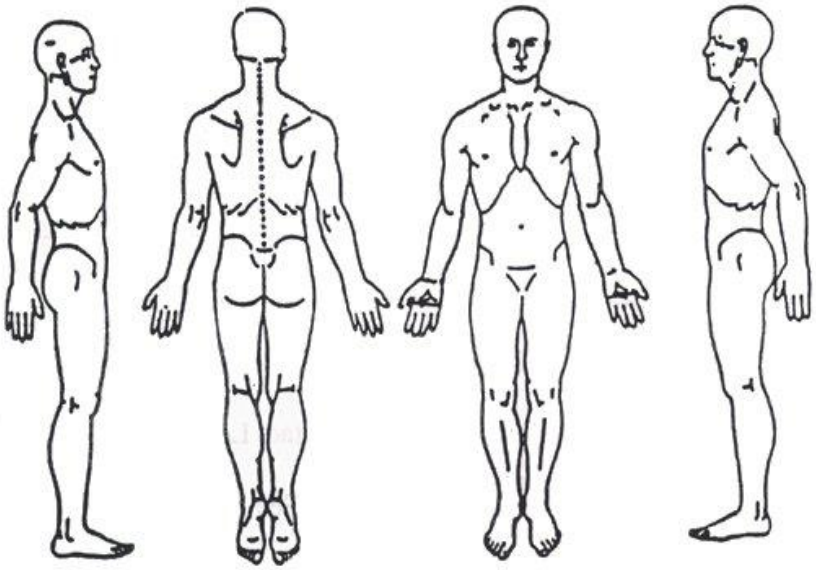
☐ Medications ☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other_____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain):_____

Type of pain:

☐ **S**harp	☐ **D**ull	☐ **Th**robbing	☐ **A**ching	☐ **S**hooting
☐ **B**urning	☐ **N**umbness	☐ **T**ingling	☐ **St**iffness	☐ **O**ther

Place appropriate highlighted letters to mark the areas of discomfort



How often is this pain? ☐ Constant (+75%) ☐ Frequent (50-75%) ☐ Occasional (25-50%) ☐ Intermit (<25%)

Does it interfere with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Other comments or concerns regarding this condition:_____

_____

INFORMED CONSENT WAIVER & AUTHORIZATION TO TREAT

I the undersigned, acknowledge by my signature, that I am aware of the participating treating Doctor of Chiropractic (D.C.) listed below, that he/she is/are a licensed chiropractor, and though rare, injury resulting from manipulation may include sprain/strain, disc herniation, stroke, death and other injuries or complications.

I agree to hold Dr. Amanda Buchanan and/or Dr. Steven Reece; any and all associated co-sponsorships of any level or participation; free and harmless from any liability, claims, demands or suits for damages from any injury or complications whatsoever, which may result from such treatment. This document is binding and the parties hereto intend this Informed Consent Waiver and Authorization to Treat to be binding on and inure to the benefit of their respective principals, heirs, executors, administrators, successors, and assigns; includes any and all my successors and/or heirs. I further state that should complications arise from such agreed treatment with the treating Doctor of Chiropractic, that such individual and myself will be the only parties to engage in any and all recourse should that need arise foregoing any and all others.

Patient Signature_____ Date_____

If patient is under18:

Guardian Signature_____ Date_____

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Financial and Insurance Disclaimer

Financial Policy

Payment in full is expected at the time service is rendered. If you have insurance coverage for chiropractic care in our office, you will be responsible for your co-payment, deductible, and/or co-insurance payment at the time of each visit. If you do not have insurance coverage for chiropractic care, you will be responsible for payment in full at the time service is rendered. In order to make this convenient, we accept most major credit cards, cash and personal checks. If, on occasion, it is not possible to pay in full, we are willing to establish a payment schedule with you. However, the balance cannot exceed $250.00 and the full balance must be paid within 30 days. Personal balances over 30 days old may be handled by an attorney for collection. Costs of collections will be added to your account and will be your responsibility.

Insurance Policy

Our office works with insurance companies to accept your coverage. Our staff will call the insurance company to verify your coverage and will explain to you the information they obtain. Upon receipt of payment and Explanation of Benefits (EOB) from your insurance company, we will know your final patient responsibility. We will then notify you of any changes or differences to the original verification quoted us. NOTE: Verification is not a guarantee of benefits. We assume no responsibility for the information we receive being correct, concerning how much or what your insurance company will pay for. The final financial responsibility is yours. Should you have questions at any time, do not hesitate to contact the staff or office manager.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Dr. Amanda Buchanan and/or Dr. Steven Reece will submit services rendered for my care for payment under the contract I have with my health and/or accident carrier. However, I understand and agree that verification of insurance is not a guarantee of benefits on all services rendered to me and I am ultimately responsible for payment. I also understand if I suspend or terminate my care and treatment, any unpaid fee for professional services rendered to me will be immediately due and payable.

Patient Signature_____ Date_____
If patient is under18:
Guardian Signature_____ Date_____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal law.

Patient Signature_____ Date_____
If patient is under18:
Guardian Signature_____ Date_____