Guthrie Chiropractic

1110 Branch St, Platte City, Mo 64079
(816)-608-3691

Confidential Patient Record

Patient Information

Name:

_____

Called name:

_____

Address:

_____

_____

SSN#:

_____

Home#:

_____

Cell# _____

Email:

_____

Can we text and email you? Yes No

Gender: M F

Age: __ DOB: __/__/__

Single Married Widowed Separated Divorced

Who referred you?_____

Occupation:

_____

Employer:

_____

Emergency Contact

_____

Phone#: _____

Relationship:_____

Insurance Information

Subscriber:

_____

Relationship: _____

DOB: __/__/__

Insurance Company:

_____

ID#: _____

GRP#: _____

Is patient covered by additional insurance?
Yes No

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____and assign directly to the doctors of Guthrie Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I clearly understand and agree that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Patient or Responsible Party's Signature

_____

Relationship Date

Confidential Patient History

Major symptoms/complaints: _____

_____

How did your symptoms start? _____ Date condition began: ____/____/____

Average pain intensity: Last 24 Hours no pain 1 2 3 4 5 6 7 8 9 10 worst pain
Past Week no pain 1 2 3 4 5 6 7 8 9 10 worst pain

How often do you experience your symptoms? ☐Constantly (76-100% of the time) ☐Frequently (51-75% of the time) ☐Occasionally (26-50% of the time) ☐Intermittently (0-25% of the time)

Describe the nature of your symptoms: ☐Sharp ☐Burning ☐Radiating ☐Shooting ☐Stabbing ☐Throbbing ☐Tightness ☐Tingling ☐Dull ☐Numb ☐Other: _____

How much have your symptoms interfered with your usual daily activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

In general, how would you say your overall health is right now?
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Have you been to a chiropractor before? When was your last visit? _____

Major injuries or surgeries: _____

Medications & Usage: _____

Family doctor: _____ Are you pregnant? ☐Yes ☐No Date of last menstrual cycle:

Have you been in an auto accident or any other personal injury? When? Describe: _____

_____

Review of Systems

Please check conditions or symptoms you currently have or have had in the past:

☐AIDS/HIV	☐Epilepsy	☐High Blood Pressure	☐Multiple Sclerosis	☐Scarlet Fever
☐Arthritis	☐Eye Problems	☐High Cholesterol	☐Nausea	☐Spinal Conditions
☐Asthma	☐Goiter	☐Jaw Pain/TMJ	☐Neurological Problems	☐Stroke
☐Balance Impaired	☐Gout	☐Kidney Disease	☐Osteoporosis	☐Thyroid problems
☐Burning Eyes	☐Headaches	☐Knee Pain	☐Pacemaker	☐Tuberculosis
☐Cancer	☐Hearing Problems	☐Lightheadedness	☐Parkinson's	☐Tumors/growths
☐Depression	☐Heart Attack	☐Liver Disease	☐Pinched Nerve	☐Ulcers
☐Diabetes	☐Heart Disease	☐Loss of Grip	☐Pneumonia	☐Varicose Veins
☐Dizziness	☐Hepatitis	☐Loss of Concentration	☐Polio	☐Whiplash
☐Drug Use	☐Hernia	☐Loss of Memory	☐Prostate problems	☐Other _____
☐Eating Disorder	☐Herniated Disc	☐Menstrual Problems	☐Psychiatric	_____
☐Elbow Pain	☐Herpes	☐Mononucleosis	☐Rheumatoid Arthritis	_____

Exercise		Work Activity		Lifestyle	
☐None	☐Daily	☐Sitting	☐Light Labor	☐Smoking Packs/Day ___	☐Coffee/Caffeine Cups/Day_____
☐Moderate	☐Heavy	☐Standing	☐Heavy Labor	☐Alcohol Drinks/Day ____	☐High Stress Level Reason: _____

_____ _____ _____

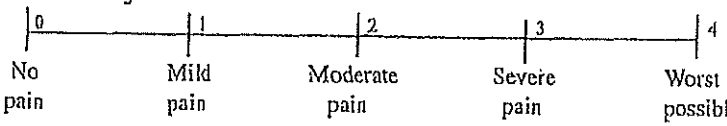
Printed Patient Name | Patient or Responsible Party's Signature | Date

Functional Rating Index

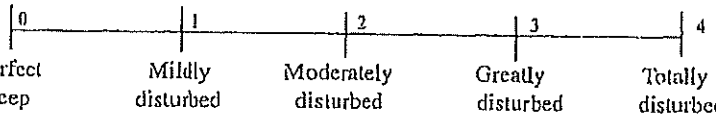
For use with Neck and/or Back Problems only.

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.

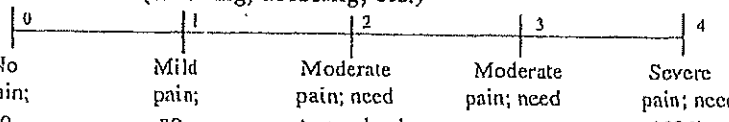
1. Pain Intensity



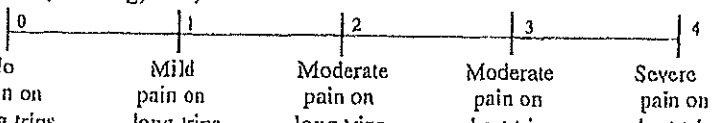
2. Sleeping



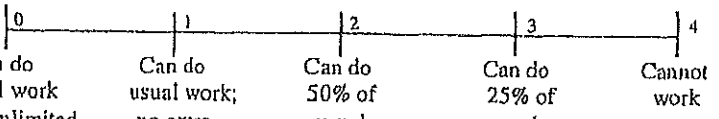
3. Personal Care (washing, dressing, etc.)



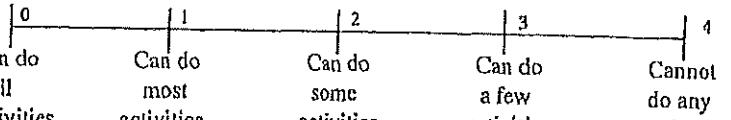
4. Travel (driving, etc.)



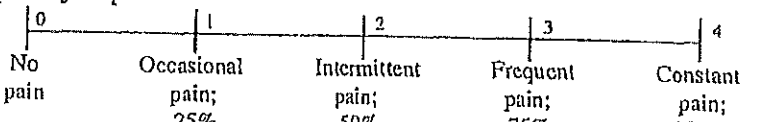
5. Work



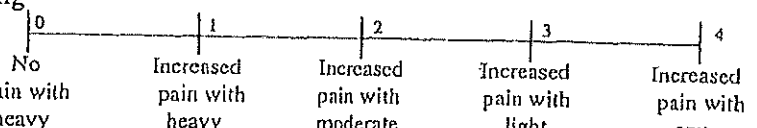
6. Recreation



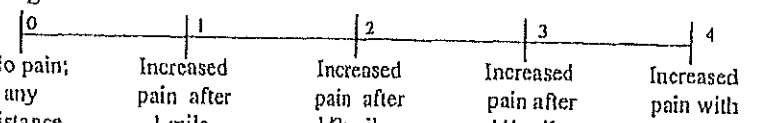
7. Frequency of pain



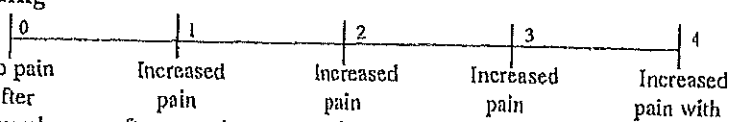
8. Lifting



9. Walking



10. Standing



Name _____ ID#/SS# _____ Plan ID _____ Total Score _____

PRINTED

_____

Signature

_____

Date

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Guthrie Chiropractic "Notice of Privacy Practices'. This notice describes how Guthrie Chiropractic may use and disclose my protected health information, certain restrictions on the use and disclosure of my health information, and rights I may have regarding my protected health information. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. Your information will be disclosed to your insurance company and physician for billing purposes and to federal and state reporting agencies. You have the right to revoke this content, in writing, except where we have already made disclosures in reliance on the content.

INFORMED CONSENT

I hereby authorize the doctor to examine and treat my conditions deemed appropriate through the use of chiropractic care, and I give authority for those procedures to be performed. I understand that chiropractic is not an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses judgement to anticipate or explain risks and complications and an undesirable result does not indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests. I further understand that there are certain degrees of risks associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

AUTHORIZATION

I give Guthrie Chiropractic the right to release any records, and pertinent material to any third party. I hereby instruct, direct, and authorize my insurance company to pay directly to Guthrie Chiropractic, for any professional services.

MY SIGNATURE IS AN ACKNOWLEGEMENT THAT I HAVE READ AND UNDERSTAND THE POLICIES ABOVE AND AGREE TO ABIDE BY THE SAME

CANCELLATION/ NO SHOW APPOINTMENT POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you or a visit, due to seemingly "full" appointment book.

IF YOU FAIL TO CANCEL OR RESCHEDULE YOUR APPOINTMENT WITHIN ONE HOUR OF YOUR SCHEDULED TIME, YOU WILL BE CHARGED A $25 FEE; THIS WILL NOT BE COVERED BY YOUR INSURANCE CARRIER.

PRINT NAME:_____

SIGNATURE: _____ DATE: _____

DRY NEEDLING CONSENT TO TREAT FORM

Dry needling (DN) is a skilled technique performed by a physical therapist using a single-use, single-insertion, sterile filiform needle, which is used to penetrate the skin or underlying tissue to effect change in body conditions, pain, movement, impairment and disability. Like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving your consent for dry needling treatment.

Risks of the procedure:

The most serious risk associated with DN is accidental puncture of a lung (pneumothorax). If this were to occur, it may require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture, while rare, may require hospitalization.

Other risks may include bruising, infection or nerve injury. It should be noted that bruising is a common occurrence and should not be a concern. The monofilament needles are very small and do not have a cutting edge; the likelihood of any significant tissue trauma from DN is unlikely. There are other conditions that require consideration so please answer the following questions:

- **Are you taking blood thinners?** Yes / No
- **Are you or is there a chance you could be pregnant?** Yes / No
- **Are you aware of any problems or have any concerns with your immune system?** Yes / No
- **Do you have any known disease or infection that can be transmitted through bodily fluids?** Yes / No

Patient's Consent:

I have read and fully understand this consent form and attest that no guarantees have been made on the success of this procedure related to my condition. I am aware that multiple treatment sessions may be required, thus this consent will cover this treatment as well as subsequent treatments by this facility. All of my questions, related to the procedure and possible risks, were answered to my satisfaction.

My signature below represents my consent to the performance of dry needling and my consent to any measures necessary to correct complications, which may result. I am aware I can withdraw my consent at any time.

I, _____ authorize the performance of Dry Needling.

_____ _____

Patient or Authorized Representative Date

_____ _____

Relationship to patient (if other than patient) Date

☐ I was offered a copy of this consent and refused.

HIPAA AUTHORIZATION FORM

Patient's Full Name _____ Patient's Social Security Number/Medical Record Number _____

Address _____ Patient's Date of Birth _____

City, State Zip Code _____ Patient's Telephone Number _____

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me: _____
2. The following person (or class of persons) may receive disclosure of protected health information about me:

   His/her/its Name _____

   Address _____

   City, State Zip Code _____
3. The specific information that should be disclosed is (please give dates of service if possible):

   _____

   _____

   _____
4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____.
7. This authorization expires on _____ OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – **note that signature is required in two places.***

Signature of Individual* (The person about whom the information relates)	Date of Individual's Signature	Date of Birth

OR, if applicable –

Signature of Guardian* or Personal Representative of Patient's Estate	Date of Guardian's/Personal Representative's Signature	Description of Authority to Act for the Individual

A copy of this completed, signed and dated form must be given to the Individual or other signator.

Official Use Only

Received	Processed By	Date