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: _____

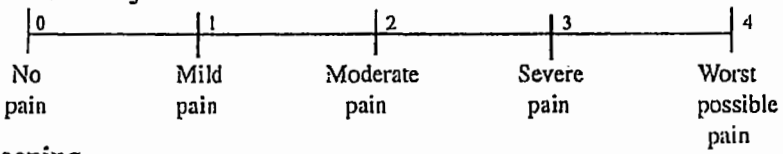
Printed Patient Name	Patient or Responsible Party's Signature	Date

Functional Rating Index

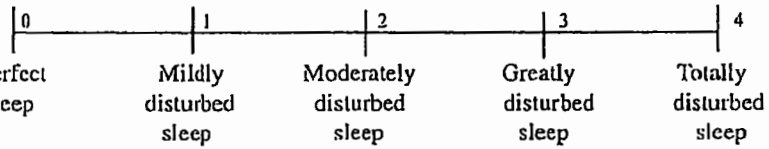
For use with Neck and/or Back Problems only.

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.

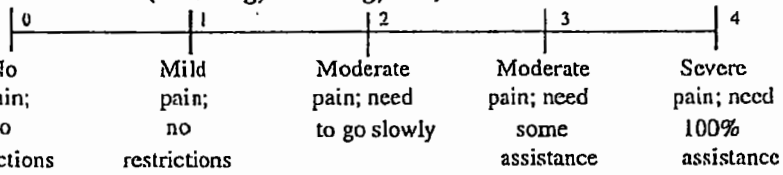
1. Pain Intensity



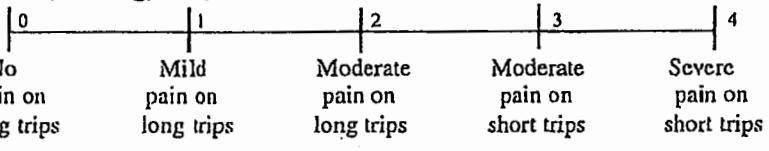
2. Sleeping



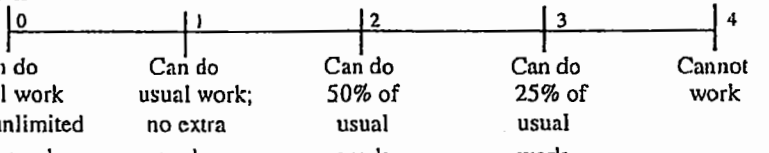
3. Personal Care (washing, dressing, etc.)



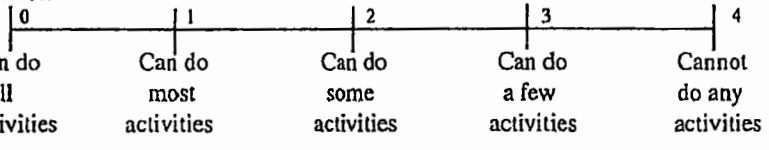
4. Travel (driving, etc.)



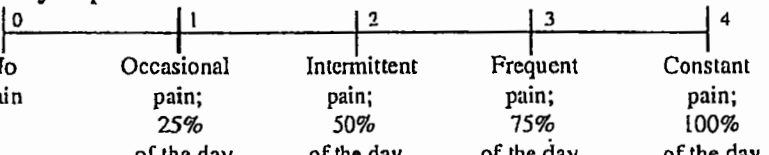
5. Work



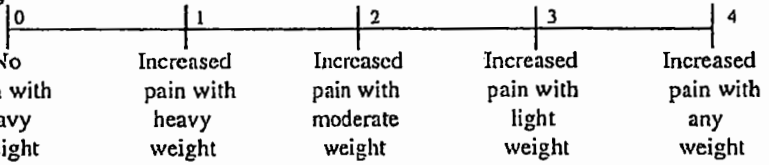
6. Recreation



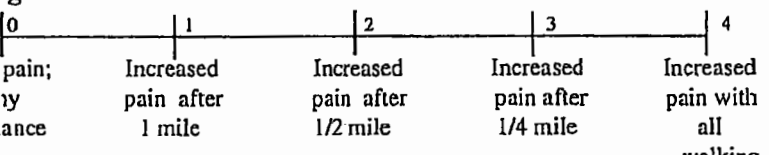
7. Frequency of pain



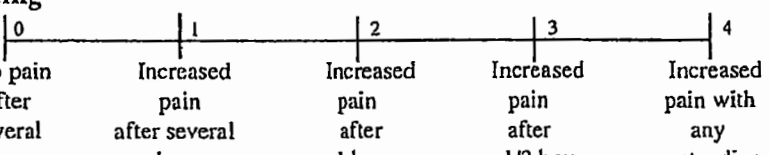
8. Lifting



9. Walking



10. Standing



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

PRINTED

_____

Signature

_____

Date

HIPAA Acknowledgment 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 healthcare 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 consent, in writing, except where we have already made disclosures in reliance on the consent.

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 judgment 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 SAME

Cancellation / No Show Policy for Doctor Appointments and Massage

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 for a visit, due to a seemingly "full" appointment book.

IF YOU FAIL TO CANCEL OR RESCHEDULE YOUR APOINTMENT BY 5PM THE DAY OF TREATMENT, YOU WILL BE CHARGED A TWENTY-FIVE ($25) FEE; THIS WILL NOT BE COVERED BY YOUR INSURANCE COMPANY.

Print Name:_____

Signature:_____ Date:_____