APPLICATION FOR CARE AT RESTORATION CHIROPRACTIC

Today's Date: _____ Referred by: _____

PATIENT INFO

Name: _____ Birth Date: ___ / ___ / ____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Fax: _____

Work Phone: _____ Email Address: _____

Employer: _____ Occupation: _____

Name of Spouse: _____ Spouse's Employer: _____

Spouse Occupation: _____ Name/Ages of Children: _____

_____

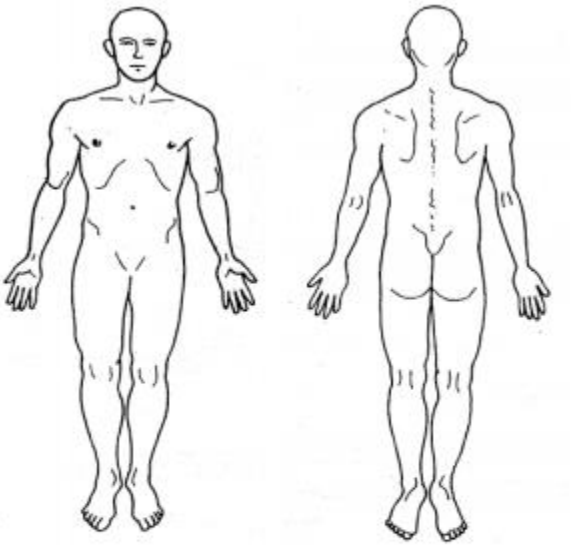
Name/# of Emergency Contact: _____ Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you here today: Please rate your complaint by circling below:

1.) _____ **No Pain** 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 -- **Worst**
2.) _____ **No Pain** 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 – **Worst**
3.) _____ **No Pain** 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 – **Worst**
4.) _____ **No Pain** 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 -- **Worst**

When did the problem(s) begin? _____ When is it at it's worst? ☐AM ☐PM or _____
How long does it last? ☐ Constant ☐ Off/On all day ☐ Comes/Goes throughout week
What relieves your symptoms? _____ What makes them worse? _____ Condition(s) ever been treated by anyone in the past? ☐ No ☐ Yes If yes, by whom? _____
If so, how long under care? _____ What were the results? _____
Name of previous Chiropractor? _____ ☐ N/A



Please mark the areas on the diagrams with the following letters to describe your symptoms: R= radiating, B= burning, D= dull, A= aching, N= numbness, S= sharp/stabbing, T= tingling, W= weakness

Is problem a result of accident? ☐ Yes ☐ No If yes, explain: ☐ Auto ☐ Work ☐ Home ☐ Other _____
Date of Accident: _____ Time of Day: _____
Have you reported this accident/if so, to whom? _____
_____
Have you suffered w/ this problem in the past: ☐ Yes ☐ No
How many times: _____ When was last time: _____
Other forms of treatment tried: ☐ Yes ☐ No What type and who was provider: _____
How long ago? _____ What were the results? _____
_____
When was most recent auto accident? _____
Speed on Impact? _____mph. ☐ Front ☐ Side ☐ Rear-end
Treatment received? ☐ Yes ☐ No If yes, by whom? _____
When was most recent stress/strain at work? _____
Were you treated? ☐ Yes ☐ No. Explain _____
Please list any other work related injuries or incidents prior to this one: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

Identify all sports or recreational activities you participate/have participated in: _____

_____

When was your most recent stress or strain during an activity? _____

Was any treatment received? ☐ Yes ☐ No If yes, explain. _____

When was the one before that? _____

PAST HISTORY

1. If you have ever been diagnosed with any of the following conditions, please indicate with a…
   "P" for "in the past," -- "C" for "Currently – and an "N" for "never had." ___ Broken Bone ___ Dislocation ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer ___ Heart Disease ___ Degenerative Disc/Joint Disease ___ Diabetes ___ Stroke ___ other serious condition -- explain here: _____

2. Please identify ALL PAST / CURRENT conditions that may be contributing to your present problem:

	How Long Ago:	Type of care received:	By Whom:
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ☐ cigarettes ☐ cigar ☐ pipe How often? ☐ Daily ☐ Weekend ☐ Occasionally ☐ Never
2. Alcohol: How often do you consume? ☐ Daily ☐ Weekend ☐ Occasionally ☐ Never :How much? _____
3. Recreational Drug Use: ☐ Daily ☐ Weekend ☐ Occasionally ☐ Never
4. Hobbies/Recreation/Exercise: Please list and check boxes to describe how problems affect activity

_____ ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to perform

_____ ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to perform

_____ ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to perform

_____ ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to perform

FAMILY HISTORY

1.Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No If Yes, who:
☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Son ☐ Daughter ☐ Grandmother ☐ Grandfather ☐ Other

2. Is there a history of Cancer, Heart Disease, or other serious conditions in your family? If so, which, & who?

_____

I hereby authorize payment to be made directly to Restoration Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Restoration Chiropractic for any and all services I receive at this office.

_____ _____

Patient or Authorized Person's Signature Date Completed

ACTIVITIES OF DAILY LIVING - - RESTORATION CHIROPRACTIC LLC

PATIENT'S NAME: _____ DATE: _____

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life. Check one box for each activity.

Walking ……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing …….	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running ……..	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading ……..	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores ……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling over……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Computer Work……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sexual Activity……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Bending……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting ……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Taking Care of Kids……	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

Patient Signature: _____ Today's Date: _____

Health Questionnaire

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ **No.:** _____

MUSCULO SKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Spasms
- ❑ Broken bones
- ❑ Shoulder pain

GENITO-URINARY SYSTEM

- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast

ARE YOU PREGNANT?
❑ YES ❑ NO

GASTRO-INTESTIONAL SYSTEM

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Difficult swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting Blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscles jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia

HABITS

- ❑ Cigarettes
- ❑ Alcohol Abuse
- ❑ Coffee or Tea
- ❑ Drug Abuse
- ❑ _____

CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficult breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose veins

EYE, EAR, NOSE AND THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficult breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw Pain

Patient's Signature _____

Restoration Chiropractic Informed Consent

Regarding Chiropractic Adjustments, Modalities and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks most often are very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Restoration Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____ / ____ / ____ _____

Patient or Authorized Person's Signature Date Witness Initials

REGARDING X-RAYS/IMAGING STUDIES

FEMALES ONLY→ please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on _____/_____/_____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

MALES/FEMALES: By my signature below, I understand and give consent to be x-rayed if the doctor deems necessary.

_____ ____/____/____ _____

Patient or Authorized Person's Signature Date Witness Initials

NOTICE OF PATIENT PRIVACY/COMMUNICATION

I,_____ hereby consent and state my preference to have my physician, Nicholas Weddle, and other staff at Restoration Chiropractic communicate with me by email or text messaging, in addition to or replace leaving phone messages regarding various aspects of my health care, which may include, but shall not be limited to, x-rays, appointments, and billing. I understand that email and text messaging are not confidential methods of communication and may be insecure. I further understand that because of this, there is a risk that email and text messaging might be intercepted and read by a third party. I give permission to leave my private health information at the following (please fill in the ones you agree to).

☐ Phone Number (__ __ __) __ __ __ - __ __ __ __

☐ Email __

PHOTO RELEASE

I authorize Restoration Chiropractic LLC/ScoliosisKC, which is a CLEAR Scoliosis Center, permission to use my words, images, and x-ray images for educational purposes, which includes presentations at seminars & conferences, promotional purposes, which includes success stories, testimonials, interviews, posters, and flyers; and research purposes, including internal data collection and the publication of data for scientific articles.

I understand the following: Restoration Chiropractic LLC/ScoliosisKC will never publish my full name, nor any other personal or identifying information (if a name is needed , only my first name will be shared). None of the information I share will ever be sold or given to third-party companies for marketing purposes, under any condition. I always retain the right to revoke my permission and request that all images and pictures be removed and deleted, at any time and for any reason. I will not be paid nor receive any type of incentive or compensation for sharing my words, images, recordings, x-rays, or other media.

Yes ☐ No ☐

_____ _____ _____

Signature of Patient/Legal Representative If Legal Representative, relationship to patient Date

CANCELLATION AGREEMENT

If for any reason you cannot keep your scheduled appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment (in some cases we have a 2-3 week waiting list).

As a courtesy to our office and other patients, please give us at least **24 hours notice**. If you do not cancel or reschedule your appointment with at least 24 hours notice, we may assess a $25 “no-show” service charge to your account. This “no show” charge is not reimbursable by your insurance company. You will be billed directly for it.

I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a no-show charge. For scoliosis intensive or 7 week treatments please refer to Deposit Policy Agreement.

Patient: _____ Date:_____

Restoration Chiropractic: Notice of Privacy Practice

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as directed by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. Once you have read this notice, please sign.

PERMITTED DISCLOSURES:

1. Treatment purposes – discussion with other health care providers involved in your care
2. Inadvertent disclosures – open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes – to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety – in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders- we may call your home and leave messages regarding a missed appointment or notify you of changes in practice hours or upcoming events.
11. Change of ownership-in the event this practice is sold, the new owners would have access to your patient information.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of this Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To request amendments to information. However, like restrictions, we are not required to agree to them.
6. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like a copy on a disc, there will be a fee, which is your responsibility.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Mary at 816-425-5578. If she is unavailable, you may make an appointment with our office assistant to see her with 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

I have read and understand Restoration Chiropractic & ScoliosisKC's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice' at any time in the future and will make the new provisions effective for all information that it maintains past and present. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____	_____	____/___/___	_____
Patient's Printed Name	Patient Signature	DOB	Date

Restoration Chiropractic: Office Policies

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your application for care, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctor at this office practices chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved, and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

- PATIENT PRIVACY – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss, please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

- YOUR CARE – When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at ScoliosisKC is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctor's use a myriad of techniques to accomplish this goal, including but not limited to the latest techniques for spinal correction. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

- FIRST THINGS FIRST – Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered to confirm the true nature of your condition and exact location of subluxations. You will be notified in advance if any further fees will be applicable. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

I hereby acknowledge that I have read and understand the practices "Office Policies'. This signature page will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all of my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____	_____	___/___/___	_____
Patient's Printed Name	Patient Signature	DOB	Date