Patient Information Form

OWENSBORO
CHIROPRACTIC & FAMILY PRACTICE
507 E. Parrish Ave.
Owensboro, KY, 42303
Phone: (270) 852-9355
Fax: (270) 852-1870

Today's Date: _____
PSR: _____

☐ New Patient ☐ Address Change ☐ Other
☐ Name Change ☐ Insurance Change

Personal Information

Last *	First*	MI*	SSN# *	Sex*
				☐ Male ☐ Female

Street Address*	City*	State*	Zip*	Date of Birth*
				/ /

Home Phone # *	Mobile Phone #	Work Phone #	Marital Status
(_ _ _) _ _ _-_ _ _ _	(_ _ _) _ _ _-_ _ _ _	(_ _ _) _ _ _ - _ _ _ _	☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer/School:	Occupation:	Would You Like to Receive Special Mailings?	Email Address:
		☐ Yes ☐ No	

Spouse/Parent/Guardian Information

Last *	First*	MI*	SSN# *	Sex*
				☐ Male ☐ Female

Street Address*	City*	State*	Zip*	Date of Birth*
				/ /

Work Phone # *	Mobile Phone #	Email	Are they retired?
(_ _ _) _ _ _-_ _ _ _	(_ _ _) _ _ _-_ _ _ _		☐ Yes ☐ No

Spouse's Occupation:	Spouse's Employer:

Physicians

Referring Physician:	Primary Care Physician Name:
Dentist:	Specialist Name:

Patient Referral Information

How did you learn about our office? ☐ Doctor Referral ☐ Family/Friend ☐ Internet ☐ Yellow Pages ☐ Insurance Company

If someone reffered you to our office, please indicate name:	May we use your name in thanking this person?	Do you use Facebook?
	☐ Yes ☐ No	☐ Yes ☐ No

Emergency Contact

Name of Person Not Living With You:	Relationship:		
Primary Phone Number:	Secondary Phone Number:		
Address:	City	State	Zip
Name of Durable Power of Attorney:	Do you have a Durable Power of Attorney?		

Are You ALLERGIC To Any Medications? ☐ Yes ☐ No

Allergen	Reaction	Allergen	Reaction

List ALL Medications Over-The-Counter and Prescribed) That You Are Taking Along with Dosages:

Medication	Dose	Medication	Dose

OWENSBORO
CHIROPRACTIC & FAMILY PRACTICE

Reason for Visit

_____

_____

_____

_____

Past Medical History (Check All That Apply)

_____Anxiety	_____Cancer (Type)	_____Heart Disease	_____Skin Disease
_____Asthma	_____Cholesterol	_____Hypertension	_____Stomach Problems
_____ADD	_____COPD	_____IBS	_____Stroke
_____ADHD	_____Depression	_____Joint Disease	_____TB
_____Alcoholism	_____Diabetes (Type)	_____Kidney Disease	_____Thyroid Disease
_____Bipolar	_____Epilepsy/Seizures	_____Kidney Stones	☐ Hypo ☐ Hyper
_____Bladder Problems	_____GERD/Reflux	_____Liver Disease	_____Stroke
_____Blood Clots	_____Gout	_____Prostate Disease	
_____Bowel Problems	_____Heart Attack	_____Psychiatric Disorder	

Other:_____

Past Surgical History (Please Check All That Apply and List Dates if Possible)

Surgery	Date	Surgery	Date
_____Appendix		_____Hysterectomy (partial/total)	
_____Back		_____Kidney	
_____Bladder		_____Laparoscopy (type)	
_____Breast (Type)		_____Prostate	
_____C-Section		_____Tonsils	
_____Cataract		_____Thyroid	
_____Skin Biopsy (Location)		_____Nerosurgery	
_____Gallbladder			
_____Hernia			

Medical History

Smoke ☐ Yes ☐ No (How Much)_____

Have You Ever Smoked? ☐Yes ☐No If yes when?_____

Drink ☐ Yes ☐ No (How Much)_____

Recreational Drug Use (Type)_____

Have You Used Drugs In The Past 3 Months? ☐ Yes ☐ No

OTC Vitamins_____

Employed ☐ Yes ☐ No

Retired ☐ Yes ☐ No

Disabled ☐ Yes ☐ No

Number of Children_____

Preventative Maintance (Please List Dates if Possible)

Pap Smear	Date
Mammogram	
Bone Density	
EKG	
Prostate Exam	
Colonoscopy	
Eye Exam	
X-Ray (Type)_____	
Routine Blood Work	
PSA	
Vaccines	

Family History

Mother: ☐ Living ☐ Deceased

Mother's Medical History_____

Father: ☐ Living ☐ Deceased

Father's Medical History_____

Signature:_____ Date:_____

If Not a Patient, Relationship:_____

For Office Use Only:

Patient#_____ | Insurance Eligibility: [ ] | EMR Scanned: [ ] | HIPPA Ack [ ]

* Indicates a required field

Owensboro Chiropractic and Family Practice

507 East Parrish Ave. Owensboro, Ky 42303

Aaron Clark D.C.

Informed Consent for Examination and Treatment

I (We) hereby consent to the performance of examination and treatment on me or on _____ by the licensed doctors of chiropractic, massage therapy, and any staff that may be employed or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor's or other clinic personnel the nature and purpose of the different chiropractic and /or physical therapy procedures and treatments. I understand the neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily 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 are in my best interests.

I further understand that there are certain degrees of risk 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.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribes for my condition and for any future conditions for which I seek treatment.

Confidentiality/ Privacy Act Form

This is to acknowledge that I _____ have been given the opportunity to review the **Notice of Privacy Practice for Owensboro Chiropractic and Family Practice.** I understand that I have the right to request a personal copy of this office's Notice of Privacy Practices. Owensboro Chiropractic and Family Practice has my permission to disclose my medical information to the following people:

Name:	Relationship:	Phone:
1.		
2.		

Patient Signature | Patient Name Printed | Date

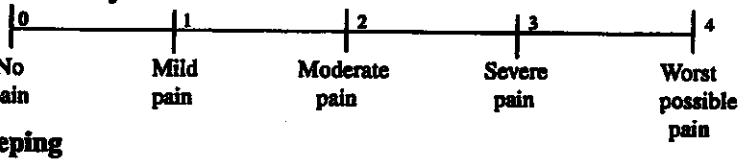
X _____

Functional Rating Index

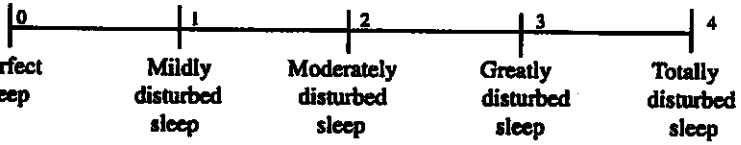
For use with **Neck and/or Back Problems** only.

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.**

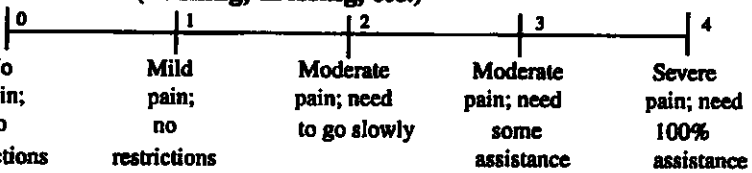
1. Pain Intensity



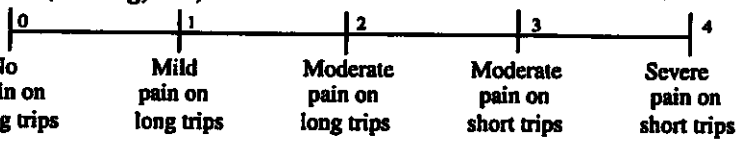
2. Sleeping



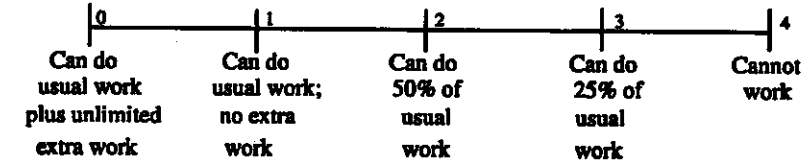
3. Personal Care (washing, dressing, etc.)



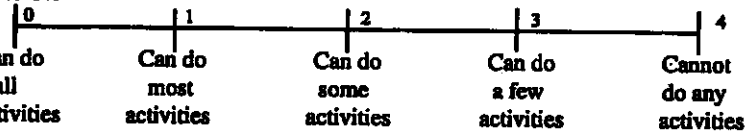
4. Travel (driving, etc.)



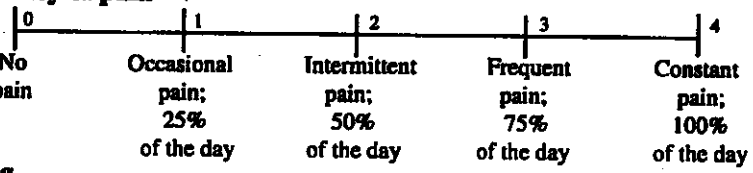
5. Work



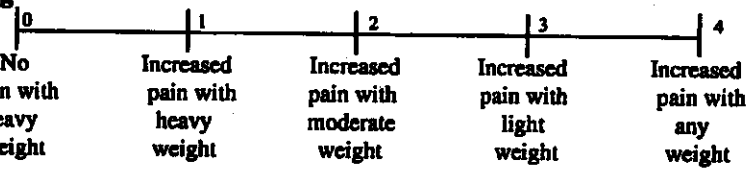
6. Recreation



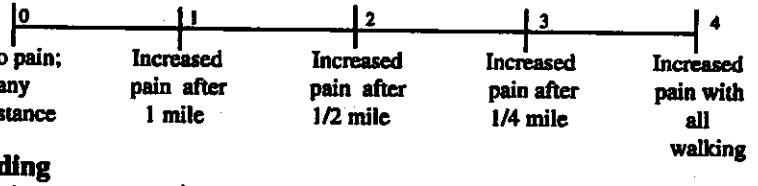
7. Frequency of pain



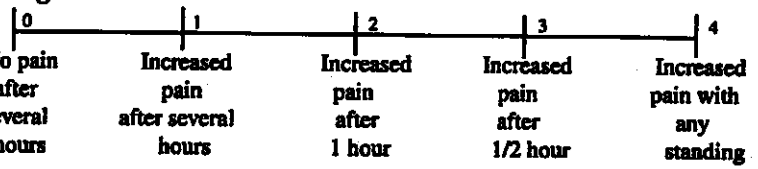
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

Attention Patient:

It is very difficult for our staff to verify each patient's insurance coverage. We encourage each of our patients to call their particular health insurance provider and simply ask "What are my chiropractic benefits?".

Please note that it is your responsibility to understand your insurance coverage and your financial obligation.

I have read and understand the above statements.

_____ _____

Sign Date