

**Olathe Chiropractic**  
16041 South Bradley Drive - Olathe, KS 66062  
Dr. Jeremy Landry & Dr. Joseph Anderson  
**New Patient Intake Form**

**Title:** (Circle one)     Mr.     Mrs.     Ms.     Miss     Dr.     Other \_\_\_\_\_

**First Name** \_\_\_\_\_ **Middle Initial** \_\_\_\_ **Last Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Leave Messages on:** (Circle one)    Home    Cell    Work    Don't leave messages

**Home Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_    **Work Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Cell Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_    **Email** \_\_\_\_\_

**Date of Birth** \_\_\_\_ / \_\_\_\_ / \_\_\_\_    **Sex:**     Male     Female

**Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_    **Marital Status:**  Single  Married  Other

**Employment Status:**  Employed     Unemployed  FT Student  PT Student     Other \_\_\_\_\_

**Employer Data**

**Employer** \_\_\_\_\_

**Your Occupation** \_\_\_\_\_

**Spouse Data**

**First Name** \_\_\_\_\_ **Middle Initial** \_\_\_\_ **Last Name** \_\_\_\_\_

**Home Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_    **Work Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Spouse Date of Birth** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Emergency Contact**

**Contact Name** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_

**Contact Home Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_    **Cell Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Doctor's Signature** \_\_\_\_\_

**How did you hear about our office?** \_\_\_\_\_

**Medical Conditions:** (Circle all that apply to you)

- |                                       |  |  |  |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Other _____  | Fibromyalgia                                 | Asthma                                 | Osteoporosis                           |

**Surgeries:** (Circle all that apply to you)

- |  |   |   |                                       |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Appendectomy        | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical spine | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint Replacement   | <input type="checkbox"/> Prostate                 | <input type="checkbox"/> Lumbar spine   | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Brain               | <input type="checkbox"/> Shoulder                 | <input type="checkbox"/> Thoracic spine | <input type="checkbox"/> Knee         |
| <input type="checkbox"/> Carpal Tunnel       | <input type="checkbox"/> Gastro-intestinal        | <input type="checkbox"/> Uro-genital    | <input type="checkbox"/> Hernia       |
| <input type="checkbox"/> Breast Augmentation | Other _____                                       |   |                                       |

**Allergies:** (Circle all that apply to you)

- |   |                                   |  |                                      |
|---|-----------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Mold           | <input type="checkbox"/> Seasonal | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Animal      |
| <input type="checkbox"/> Chemical _____ | Sulfites                          | <input type="checkbox"/> Wheat/Glutens   | <input type="checkbox"/> Other _____ |

**Social History:** (Circle all that apply to you)

- Caffeine use:     occasional     often     never  
Drink Alcohol:     occasional     often     never  
Exercise:  occasional  often  never    Drink Water:  <64 oz/day  >64 oz/day  
 never  
Cigarettes:     <1 pack/day     >1 pack/day     never  
Sleep:     <8 hours/night     >=8 hours/night    Insomnia Other
- \_\_\_\_\_

**Family History:** (Circle all that apply)

- Arthritis:     Parent     Sibling  
Cancer:  Parent  Sibling    Diabetes:  Parent  Sibling  
Heart Disease  Parent     Sibling  
Hypertension  Parent     Sibling  
Stroke  Parent     Sibling  
Thyroid     Parent     Sibling  
Other \_\_\_\_\_

**Occupational Activities:** (Circle one that best describes your job description)

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Administration           | <input type="checkbox"/> Business Owner      | <input type="checkbox"/> Clerical/Secretary | <input type="checkbox"/> Computer User                              |
| <input type="checkbox"/> Heavy Equipment operator | <input type="checkbox"/> Daycare/Childcare   | <input type="checkbox"/> Construction       | <input type="checkbox"/> Health Care                                |
| <input type="checkbox"/> Food Service Industry    | <input type="checkbox"/> Medium Manual Labor | <input type="checkbox"/> Manufacturing      | <input type="checkbox"/> Home Services                              |
| <input type="checkbox"/> Heavy Manual Labor       | <input type="checkbox"/> Light Manual Labor  | <input type="checkbox"/> Executive/Legal    | <input type="checkbox"/> Housekeeper <input type="checkbox"/> Other |
- \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Review of Systems** – (Check box if you have had trouble with any of the following)

<b>Cardiovascular</b>			No	<b>Respiratory</b>			No	<b>Allergic/Immunologic</b>			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								<b>Ear, Nose and Throat</b>			No
Jaw Pain				<b>Eyes</b>			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
<b>Genitourinary</b>			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				<b>Psychiatric</b>			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				<b>Gastrointestinal</b>			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				<b>Endocrine</b>			No	Bowel Problems			
<b>Neurologic</b>			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			

Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				<b>Hematologic</b>			No				
Pinched Nerves					Past	Present		<b>Musculoskeletal</b>			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
<b>Constitutional</b>			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

Please list all current medications being taken \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**How are your symptoms changing?** Getting better  Not changing  Getting worse

**Are You Pregnant?** (Circle) **Yes**      **No**

Doctor's Signature \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

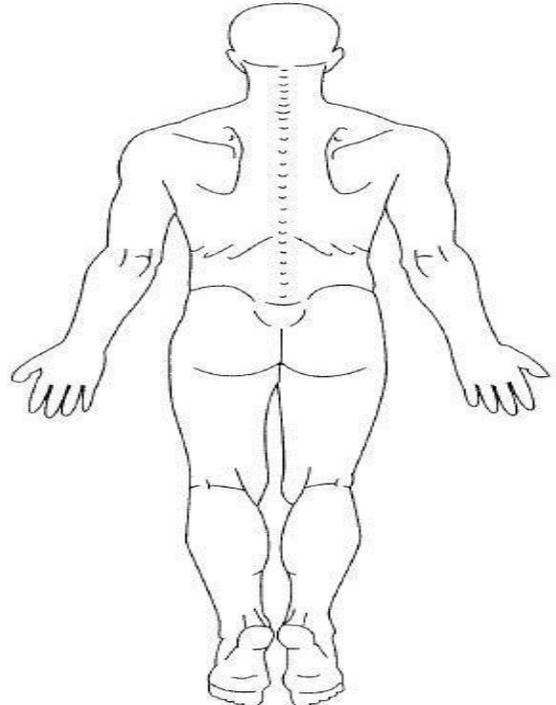
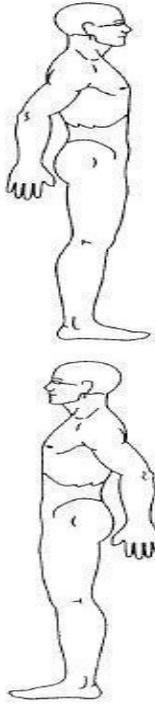
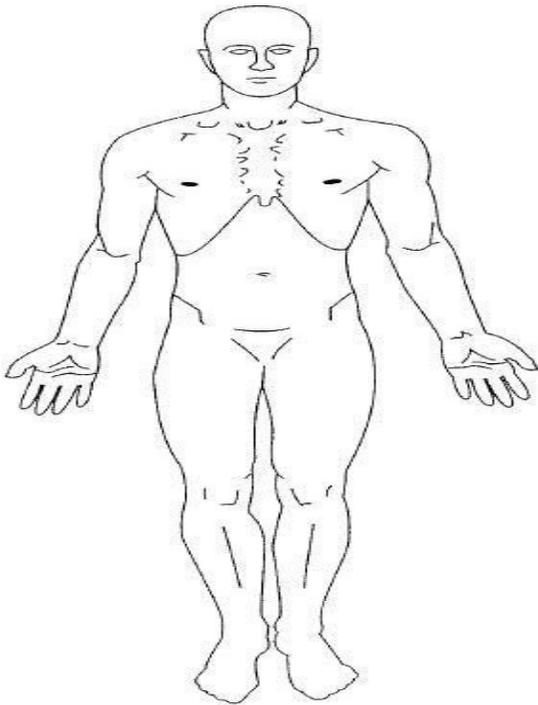
N=Numbness

B=Burning

S=Sharp

T=Tingling

A=Dull Ache



**Average Pain Intensity:**

Last 24 hours: no pain 0 1 2 3 4 5 6 7  
 8 9 10 worst pain Past week: no pain 0 1 2  
 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No **If Yes, please list:**

When did your symptoms begin?

Are your symptoms a result of:  Motor Vehicle Accident  Work related Accident  Other \_\_\_\_\_

How did your symptoms begin? \_\_\_\_\_

**How often do you experience your symptoms?**

Constantly (76-100% of the day)  Frequently (51-75% of the day)  Occasionally (26-50% of the day)  Intermittently (0-25% of the day)

**What describes the nature of your symptoms?**

Sharp  Ache  Numb  Shooting  
 Burning  Tingling  Throbbing  Other \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

## Olathe Chiropractic

### PAYMENT POLICY

Thank you for choosing Olathe Chiropractic as your chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. **INSURANCE.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral, it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
2. **CO-PAYMENT AND DEDUCTIBLES.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help is in upholding the law by paying your co-payment at each visit.
3. **PROOF OF INSURANCE.** All patients must complete our patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. **CLAIM SUBMISSION.** We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. **CONVERAGE CHANGES.** If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
6. **MISSED APPOINTMENT.** Our policy is to charge \$25.00 after **one** missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you. **Please help us to serve you better by keeping your regular scheduled appointment.**

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

**I have read and understood the payment policy and agree to abide by its guidelines.**

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Signature of patient or responsible party

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Date

## Terms of Acceptance

Chiropractic care is a safe and effective approach for many health conditions, however as with any health care procedures, chiropractic treatment present the risks of complications or negative side effects. The list below includes the various treatments available in our clinics and the potential risks associated with them.

### CHIROPRACTIC MANIPULATION

The risks associated with chiropractic treatments include, but are not limited to, dislocations and sprains, disc injuries, fractures, and strokes. These negative effects are very rare, and your doctor has done a careful screening for the contraindications during the consultation and examination. Another more common side effect associated with chiropractic manipulation therapy is some soreness or stiffness following the treatment. The use of ice packs is recommended to reduce the discomfort.

### COLD THERAPY

We place a towel around the pack to minimize the contact with the skin which can cause a local burn. If you have very sensitive skin, you can experience a reaction.

### ELECTROTHERAPY

A small defect in the electrode coating, not always detectable by observation, may concentrate the current, causing a small burn to the skin. If you feel a sting where the electrode is place, please inform us. Electric stimulation causes muscles to contract and in rare instances a muscle cramp may occur during such treatment. Inform us if the procedure is uncomfortable.

### COLD LASER THERAPY

Generally, there are no side effects for cold laser therapy. The potential risk associated with this therapy is damage to the eye when the beam is pointed directly into the eye.

Any request for records must be done in writing, and the records will be available in 2 business days.

I understand I will be responsible for payment of services, and all fees are due BEFORE services are rendered. I also understand that I will be charged a collection fee if I do not pay in a timely manner and returned check fees.

I, \_\_\_\_\_ have read and fully understand the above statements. (Print  
Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

**Olathe Chiropractic**  
**Appointment Reminders and Health Care Information**  
**Authorization**

Your doctor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released, or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§ 164.524)

This notice is effective as of \_\_\_\_\_. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date of Signing

\_\_\_\_\_  
Description of Personal Representative's Authority