John Carey, D.C. 7329 Broadway (Wornall Road) Kansas City, MO 64114

CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient: please complete this questionnaire. Your answers will help us determine if chiropractic can help you. Thank You.

Full Name:_____ DOB:_____ AGE: _____ Gender: M F

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

Home Phone: _____ Work phone: _____ Cell Phone: _____

Your Employer: _____ Your Occupation: _____

Employer address: _____ City:_____ State: _____ Zip: _____

Person responsible for this account: _____ E-mail: _____

Referred By: _____ Insurance Plan/Policy #: _____/_____

History of Present Injury/Illness: Please list below the complaint(s) you have in order of importance, also the length of time you had these complaint(s).

1. _____ How Long? _____
2. _____ How Long? _____
3. _____ How Long? _____

Is your condition related to an accident? ☐ Yes ☐ No If yes describe: _____

Ever had a similar episode before? ☐ Yes ☐ No Describe your condition: ☐ getting worse ☐ the same ☐ getting better ☐ constant ☐ comes + goes

What activities aggravate your condition? _____ What makes your condition better? _____

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other: _____

Have you seen any other health care provider for your present condition? ☐ Yes ☐ No Who? _____

List previous diagnoses and treatments you have received for your present condition? _____

List all medications you presently take: _____

Past History: List any surgeries you have had

1. _____ Date: _____ 3. _____ Date:_____
2. _____ Date:_____ 4. _____ Date: _____

Have you ever been involved in a motor vehicle accident? ☐ Past year ☐ Past five years ☐ Over five years ☐ Never

Describe: _____

Have you ever:	Yes	No	Describe Briefly:
Been knocked unconscious?	☐	☐	
Used a crutch, cane, or other support?	☐	☐	
Been treated for a spine or nerve disorder?	☐	☐	
Had a fracture or broken bone?	☐	☐	
Hospitalized other than surgery?	☐	☐	
Do you:			
Take vitamins, minerals, or herbs?	☐	☐	
Take supplements?	☐	☐	

Habits:	Heavy	Moderate	Light	None	Comments:
Alcohol	☐	☐	☐	☐	
Tobacco	☐	☐	☐	☐	
Drugs	☐	☐	☐	☐	
Exercise	☐	☐	☐	☐	
Appetite	☐	☐	☐	☐	

In case of an emergency who should we contact?

#1 Name: _____ Relationship: _____ Phone: _____

#2 Name: _____ Relationship: _____ Phone: _____

Please check the appropriate box for any of the following symptoms which you have now or have had previously. We want all the facts about your health before we accept your case. This is a confidential health report.

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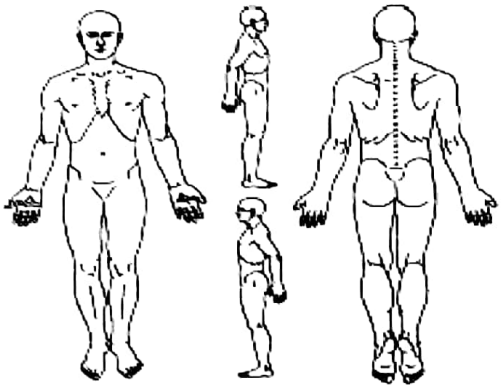
CONFIDENTIAL PATIENT CASE HISTORY



On the drawing to the left, circle the area(s) where you have pain.
Then, *for each area that you have circled*, designate a number from *0 to 10* (**with 10 being the most pain**) that corresponds to your ***current*** pain level.

0-10	Burning	Sharp	Numb	Tingling	Ache	Other
___ Headache	☐	☐	☐	☐	☐	☐
___ Neck	☐	☐	☐	☐	☐	☐
___ Shoulder	☐	☐	☐	☐	☐	☐
___ Mid Back	☐	☐	☐	☐	☐	☐
___ Elbow	☐	☐	☐	☐	☐	☐
___ Wrist	☐	☐	☐	☐	☐	☐
___ Low back	☐	☐	☐	☐	☐	☐
___ Hip	☐	☐	☐	☐	☐	☐
___ Knee	☐	☐	☐	☐	☐	☐
___ Ankle	☐	☐	☐	☐	☐	☐
___ Foot	☐	☐	☐	☐	☐	☐
___ Other _____	☐	☐	☐	☐	☐	☐

P – Previous C – Current

P	C	
		General
☐	☐	Allergy / Hay fever
☐	☐	Convulsions / Tremors
☐	☐	Dizziness
☐	☐	Depression / Anxiety
☐	☐	Fainting
☐	☐	Fatigue
☐	☐	Insomnia
☐	☐	Loss of Weight
☐	☐	Night Sweats
		Muscle & Joint
☐	☐	Arthritis
☐	☐	Bursitis / Swollen Joints
☐	☐	Night Pain
☐	☐	Muscle cramps at night
☐	☐	Muscle weakness
☐	☐	Scoliosis
☐	☐	Stiffness
☐	☐	Surgical implant

P	C	
		Gastro-Intestinal
☐	☐	Belching or gas
☐	☐	Bloating after meals
☐	☐	Constipation / Diarrhea
☐	☐	Gall bladder removed
☐	☐	Colitis
		EENT
☐	☐	Deviated septum
☐	☐	Frequent colds / ear infections
☐	☐	Nosebleeds
☐	☐	Tinnitis
		Endocrine
☐	☐	Afternoon headaches
☐	☐	Crave salt
☐	☐	Coarse or thinning hair
☐	☐	Get "shaky" if hungry
☐	☐	Inability to concentrate
☐	☐	Increase in weight
☐	☐	Sensitive to cold
		Skin
☐	☐	Bruise easily
☐	☐	Hives / rash

P	C	
		Cardio-Vascular
☐	☐	Asthma
☐	☐	Chest Pain
☐	☐	Chronic cough
☐	☐	Difficulty breathing / Wheezing
☐	☐	Hardening of arteries
☐	☐	High / Low blood pressure
☐	☐	Pain over heart / chest pain
☐	☐	Spitting up blood / phlegm
☐	☐	Swelling of ankles
		Genito-urinary
☐	☐	Bed-wetting
☐	☐	Unable to control kidneys
☐	☐	Painful urination
☐	☐	Frequent urination
☐	☐	Prostate trouble
		For Women Only
☐	☐	Hot flashes
☐	☐	Irregular / Painful / Excessive menses
☐	☐	Painful breasts
☐	☐	Premenstrual tension

☐ Yes ☐ No Are you pregnant?

Family History: Check the following condition that applies for you, mother, and father

	You	Mother	Father	explain
☐ Cancer	☐	☐	☐	☐ _____
☐ Diabetes	☐	☐	☐	☐ _____
☐ Heart disease	☐	☐	☐	☐ _____
☐ HIV/AIDS	☐	☐	☐	☐ _____
☐ Multiple sclerosis	☐	☐	☐	☐ _____
☐ Pace maker	☐	☐	☐	☐ _____
☐ Rheumatoid arthritis	☐	☐	☐	☐ _____
☐ Stroke	☐	☐	☐	☐ _____

(Signs/Symptoms of stroke include: dizziness, one sided numbness/tingling, muscle weakness or face drooping, trouble swallowing or speaking, "worst headache ever" pain, double vision)

- I have read the Consent to Treatment for chiropractic and I have freely decided to undergo the recommended treatment.
- I allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
- I've been informed and understand my rights concerning HIPPA Notice of Privacy Practices, and Use and Disclosure of Protected Health Information. (Once information is disclosed, it may not be protected by law.)
- I give this office authorization to use my name for any in-office publications.
- Authorization may be denied or retracted at any time by notifying the office manager.
- I authorize payment of medical benefits to this office.

Patient signature: _____ Date: _____

Guardian's signature: _____ Date: _____

(Authorization expires 3 years from above date)

Carey Chiropractic
Dr. John Carey

What general activities in your life are affected by your complaint(s)? Check all that apply.

- ☐ Employment
- ☐ Homemaking
- ☐ Lifting
- ☐ Personal Care (washing, dressing, etc)
- ☐ Sitting
- ☐ Sleeping
- ☐ Social Life
- ☐ Standing
- ☐ Traveling and/or Driving
- ☐ Walking
- ☐ Other
    - If other please explain:_____

What specific activities are difficult due to your specific complaint(s)? Check all that apply.

- ☐ Bending over
- ☐ Caring for family
- ☐ Climbing stairs
- ☐ Concentrating
- ☐ Dressing self
- ☐ Driving car
- ☐ Exercising
- ☐ Getting in/out of car
- ☐ Getting to sleep
- ☐ Grocery shopping
- ☐ Performing household chores
- ☐ Lifting objects
- ☐ Looking over shoulder
- ☐ Lying down
- ☐ Reaching overhead
- ☐ Rising out of chair or bed
- ☐ Showering or bathing
- ☐ Sitting
- ☐ Standing
- ☐ Staying asleep
- ☐ Using a computer
- ☐ Walking
- ☐ Participating in yard work
- ☐ Other
    - If other please explain:_____

Carey Chiropractic
Dr. John Carey

Cell Phone Text Reminders

Would you like to receive appointment reminders by text?

If so the fill out the spaces provided below:

Cell Phone Number:_____

Cell Provider:_____

Circle how much notice you would like for your appointment reminder:

1 Hour 2 Hours 4 Hours 1 Day 2 Days

Dr. John Carey

Consent Agreement

Dear Patient:

You have a right, as a patient, to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used, so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

In the practice of chiropractic there are some risks to examination and treatment procedures including, but not limited to, fractures, disc injuries, dislocations, sprains and increased symptoms and pain, or no improvement of the symptoms or pain. A rare but serious risk associated with neck manipulation is stroke.

The Doctor of Chiropractic is not able to anticipate and explain all risks and complications but relies on clinical judgment based on all the facts known at the time of the procedure, and makes decisions that, according to the facts available, are to the best interest of the patient. There are no guaranties or assurances concerning the intended results of the treatments.

Consent for Treatment

I understand that my outpatient registration, treatment or series of treatments by Dr. John Carey, D.C. is necessary because of my condition, I voluntarily authorize and consent to the usual examination and treatments, including x-rays, ordered by the Doctor and staff.

Request for Records

I hereby authorize Dr. Carey to request any medical records, x-rays, and specialized testing results, including serum and tissue testing results for the purpose of giving a better diagnostic picture. I permit a copy of this authorization to be used in requesting my records from any and all health care facilities, Physician and health care providers.

Payment and Insurance Release

I permit a copy of this authorization to be used in place of the original by Dr. John Carey, D.C. I authorize release to the Health Care Financing Administration and its agents any information needed to determine these benefits are payable. I authorize any holder of medical information about me to be released to any of the above named health insurance or their contracted claims paying agents, and all information necessary to determine if these benefits are payable.

When I pay by check, I expressly authorize this provider, if my check is dishonored or returned from any reason to debit my account for the amount of the check plus a processing fee of $20.00 (plus any applicable sales tax). The use of a check for payment is my acknowledgement and acceptance of this policy and its terms.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. That said, I understand and agree that all services rendered me are charged directly to me and are immediately due and payable. I further agree and understand that if the need arises, accounts delinquent by 90 days may be placed into a legal collection status. I understand and agree that I am responsible for all court costs, collection agency fees, filing fees and attorney fees that are incurred to collect my debt.

_____	_____
Date	Patient's Signature
_____	_____
Witnessed By:	Patient Guardian's Signature (if applicable)

Consent for Treatment of a Minor

I (We) bring the parent, guardian, or custodians _____ of a minor, the age of___, do hereby authorize, request ad direct Dr. John Carey, D.C. to perform in his judgment any necessary examinations, X-ray(s) and recommend treatment plan for the condition.

Dr. John Carey

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. Please review it carefully.

A signed consent form permits us to use your personal health information within our office for the purpose of treatment, receiving payment, and health care operations of our practice. It is the policy of this practice to release only the minimum necessary information to any source not directly linked to hands-on care and treatment of patients in our office as outlined in the Health Insurance Portability Accountability Act of 1996 (HIPPA).

This includes third party payers, insurance companies, etc. In these cases your signed consent form permits us to release only enough information to complete the insurance claim process. In some cases, patients may wish to have their protected health information released. In those cases if the outside entity can provide us with a copy of a medical records release form signed by the patient then we will comply while still providing only the minimum necessary information, or the amount of information requested by the patient.

In cases of public health, HIPAA does not protect some information. Where we are required by law to release information to any law enforcement or public health agency, our office will only release the minimum information required by law to any outside entity. In all cases we will follow the most restrictive laws, state, or federal, that apply in protecting your medical information. You, as a patient, have a right to see your medical record during normal office hours.

ADDITIONAL USES OF YOUR HEALTH INFORMATION:

Our staff may use your health information to remind you of appointments, send birthday or seasonal greeting cards, mailings, newsletters, information about our practice or other information we feel you may be interested in or may improve your health. We will NOT release a mailing list to any outside entity for solicitation of business not related to our office.

Dr. John Carey, D.C.

Personal Medical Information Consent Form

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason. This consent form gives us permission to use your Protected Health Information (PHI) or carry out treatment, receive and/or use as part of health care operations of our practice. HIPAA also requires us to have a written notice of our Privacy Policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read. You have the right to revoke, in writing, this consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent.

_____ _____

Date Patient (or Guardian's if applicable) Signature

Restrictions: _____

Doctor/Staff Signature

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our office's policies and practices may be required by changes in federal or state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. These revised policies and practices will be applied to all protected health information we maintain.