



Dr. Jeremy Will, D.C.
208 W 6th St
Concordia, KS 66901
785-262-4344

Patient Information

Date _____

Patient Name _____

Sex: M F

Birthdate _____

SS# _____

Marital Status: S M D W

Address _____

City _____

State _____

Zip _____

Home # _____

Cell # _____

Email _____

(This information will NOT be shared with any third party.)

Occupation _____

Employer/School _____

Employer/School Address _____

City _____

State _____

Zip _____

Spouse/Parent/Legal Guardian Name _____

Spouse/Parent/Legal Guardian Employer _____

Who is your primary physician? _____

Emergency Contact _____

Phone _____

Relationship to the patient _____

Whom may we thank for referring you? _____

Or how did you hear about us? _____

Have you seen a chiropractor before? Yes No If so, when was your last visit? _____

What is the nature of your visit today? (please circle one)

Personal Injury

Chronic/Ongoing Pain

Auto Accident

Work-Related Injury

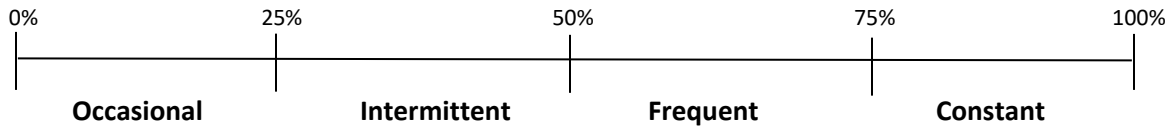
Wellness

Chief Complaint

Initial Date of Injury/Accident/Symptoms _____

Briefly describe the primary reason for today's visit. _____

How frequent is the pain on most days? (Please mark an "X" on the line) *can be different frequencies for different conditions



Does your pain/injury interfere with any of the following? (Please circle all that apply)

Sleep Work Daily Routine Sport Hobby (describe) _____

Please rate the intensity of the pain with 0 being no pain and 10 being unbearable, excruciating pain.

0 1 2 3 4 5 6 7 8 9 10

Is there anything you can do to INCREASE the pain? _____

(examples: putting on shoes, turning a certain direction, prolonged standing/sitting, reaching, walking, lifting)

Is there anything you can do to DECREASE the pain? _____

(examples: Tylenol, Ibuprofen, ice, heat, sleep/rest, walking, stretching)

Please indicate on the body diagram where you feel the most pain, including all affected areas.

Use the symbols given below to describe the pain in the given area.

Numbness/Burning

XXXXXXXXXXXX

Deep/Dull

+++++

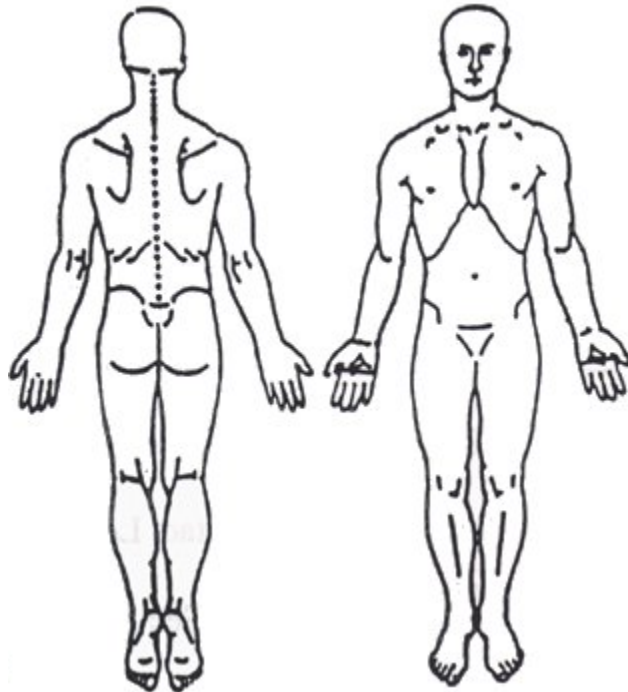
Aching/Stiffness

OOOOOOOO

Tingling/Radiating

Sharp/Stabbing

//////////



Have you received previous treatment for this injury? Yes No

If yes, please explain

Have you received any diagnostic imaging (X-Ray, MRI, CT) for this injury? Yes No

If yes, please list imaging procedure and date _____

Past Medical History

Have you had any previous major injuries (broken bones, major sprains, dislocations)? If yes, please list.

Have you had any previous surgeries? If yes, please list and the date performed.

Have you been hospitalized within the last 5 years? Yes No
If yes, briefly describe the reason _____

Have you been involved in a car accident recently? Yes No If so, when? _____

List all current medications _____

List all current vitamins/supplements _____

Check the box if you have or have had any of the following conditions:

General

- Allergies
- Depression
- Dizziness
- Fainting
- Headaches
- Loss of sleep
- Nervousness
- Tremors
- Numbness/
Tingling
- Weight loss / gain

Muscle / Joint

- Arthritis
- Foot trouble
- Muscle weakness
- Joint pain

Eye, Ear, Nose &

Throat

- Deafness
- Ear ache
- Eye pain

- Nasal obstruction
- Nose bleeds
- Ringing in ears
- Sinus infection
- Sore throat
- Tonsillitis
- Vision problems

Gastrointestinal

- Abdominal pain
- Bloody/tarry stool
- Colitis / Crohn's
- Constipation
- Diarrhea
- Excessive hunger
- Gallbladder trouble
- Hernia
- Liver trouble
- Nausea
- Poor appetite
- Vomiting of blood

Genitourinary

- Bed-wetting

- Bladder infection
- Blood in urine
- Kidney infection
- Kidney stones
- Prostate trouble
- Stress incontinence

Cardiovascular

- High blood pressure
- High cholesterol
- Hardened arteries
- Irregular pulse
- Palpitation
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

Respiratory

- Chest pain
- Chronic cough
- Difficulty breathing
- Hay fever

- Shortness of breath
- Spitting up blood
- Wheezing

Women only

Are you pregnant?
 yes, no
If yes, how many months? _____
How many children do you have? _____
Birth control method:

Social

(please indicate frequency/amount)
Smoking _____
Tobacco _____
Alcohol _____
Caffeine _____
Water _____
Exercise _____

Patient Name _____

Authorization

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to Concordia Spine & Sport, LLC.

I authorize Concordia Spine & Sport, LLC and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature _____
(or Legal Guardian)

Date _____

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment. There are some risks that may be associated with treatment, in particular you should note:

- While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment
- There have been rare reported cases of disc injuries following cervical and lumbar spinal Adjustment, although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
- There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed the following with my healthcare provider:

1. The condition that the treatment is to address;
2. The nature of the treatment;
3. The risks and benefits of that treatment; and
4. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with Concordia Spine & Sport, LLC.

Patient Signature _____
(or Legal Guardian)

Date _____

Print Name _____

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

Patient

Signature

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the Acknowledgment
- An emergency situation prevented us from obtaining Acknowledgment
- Other (Please Specify)

—

Staff signature

Date