Sand Springs Chiropractic
413 E Broadway St
Sand Springs OK 74063
918-246-5808

Dr. Alex Kvach DC

BASIC INFORMATION

Please Write Legibly

Name: _____ DATE: _____

Birth Date: ___/___/_____ Age: _____ Marital: [M] [S] [W] [D] # Children: _____

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

E-mail: _____ Cell Phone#: (___) ___- _____

How did you find our office? _____

Occupation: _____ Employer: _____ Years worked: _____

Spouse: _____ Occupation: _____ Employer: _____

Emergency contact: _____ Relationship: _____ Phone#: (___) ___-_____

Family doctor: _____ Phone#: (___) ____-_____

May we contact your doctor regarding your chiropractic care? [Y] [N]

Insurance company: _____ [ ] Uninsured

Medical History

Purpose of appointment: _____

Date current symptoms appeared: ____/____/_____ have you ever had the same or a similar condition?
[Yes] [No]

If yes, when, and describe: _____

_____

Days lost from work due to current condition: _____

What surgeries have you had? _____

_____

Date of last physical exam: ___/___/_____

Describe any serious illnesses you've been treated for in the last year: _____

_____

List any medications or drugs you are taking: _____

_____

_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of (16%). The patient understands and agrees to allow this chiropractic office to contact them via phone, fax, email or other electronic means. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detaJ1ed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient or guardian's signature: _____ Date: _____

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Name: _____ DATE: _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any healthcare operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum required by the insurance companies for payment. The patient agrees to allow this chiropractic office to contact them via electronic means such as phone, fax, email, etc.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.
5. To preserve your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and healthcare operations, the healthcare provider has the right to refuse to give care.

SIGNATURE_____ DATE_____

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Patient Consultation & Case History

NAME: _____ DATE: _____

Foot, leg, hip	Hand, arm, shoulder	Back, neck, jaw
☐foot pain	☐hand pain	☐neck pain
☐foot numbness	☐hand numbness	☐headaches
☐knee pain	☐elbow pain	☐mid back pain
☐hip pain	☐shoulder pain	☐TMJ/Jaw
☐ankle pain	☐arm numbness	☐lower back pain
☐toe pain	☐wrist pain	☐sciatic nerve pain

1: What symptoms are you experiencing: _____

2: When did you first notice the problem? _____

3: How did it originally occur? _____

_____

3: Has it gotten worse-recently? ☐yes ☐no ☐same ☐better ☐gradually worse

4: How frequent is the condition? ☐constant ☐daily ☐intermittent ☐night only

5: How long does it last? ☐all day ☐few hours ☐minutes

6: Describe any other conditions related to your major symptom: _____

7: Describe any unrelated health problems: _____

8: Describe your pain: ☐sharp ☐dull ☐numbness ☐tingling ☐aching ☐burning ☐Other: _____

_____

9: Daily Activities this has made harder to do? (ie: dressing, brushing teeth) **Please rate from 1-10.** 1: can't do at all 10: no issue doing

1. _____ 10 2. _____ 10 3. _____ 10

10: Describe anything you've tried that has **helped** the problem: _____

11: Describe anything you've tried that has **NOT** helped the problem: _____

12: What makes the problem worse? ☐standing ☐sitting ☐lying ☐bending ☐lifting ☐twisting
☐Other: _____

13: List any major accidents you've had other than the ones above: _____

14: Have you had any diseases, major illnesses, or injuries not indicated on this form? Explain: _____

_____

WOMEN: Are you, or is there a possibility you could be, pregnant? ☐yes ☐no ☐uncertain

Other Remarks about this issue: _____

Indicate the level of the problem

NO SYMPTOMS ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **EXTREME SYMPTOMS**

Patient Signature: _____ Date: _____

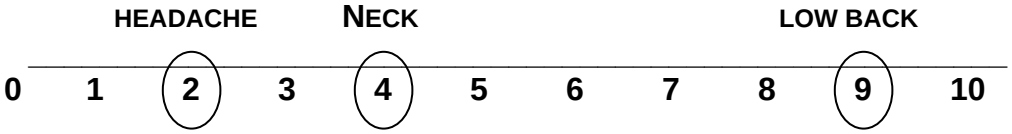
QUADRUPLE VISUAL ANALOGUE SCALE

Name _____ Number _____ Date _____

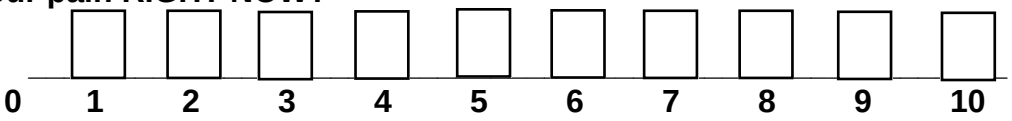
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

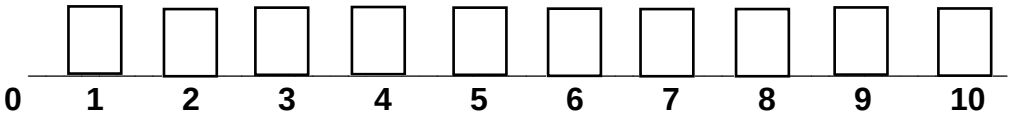
EXAMPLE:



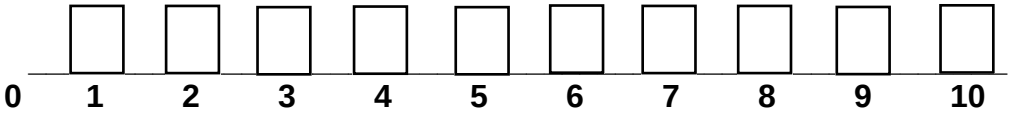
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

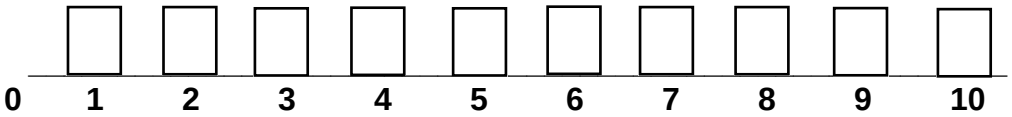


3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? _____%

Reference: Thomeé R., Grimby G., Wright B.D., Linacre J.M. (1995) Rasch analysis of Visual Analog Scale. *Scandinavian Journal of Rehabilitation Medicine* 27, 145-151.