Welcome to Our Office

KIRK CHIROPRACTIC & WELLNESS CENTER
8514 N 128th E Ave Owasso, OK 74055 (918) 272-6200

PATIENT INFORMATION		
Name:		
Preferred Name:	Date of birth:	SSN:
Cell Phone:	Home Ph:	
Married____ Single____ Other____	No. of Children _____	
Current address:		
City:	State:	ZIP Code:
Employer:	Occupation:	
Email Address:		
Appointment Reminder: Text or Email (Circle One)		
Cell phone carrier: _____ (Needed for Text Reminders)		
INSURANCE INFORMATION		
Name of **Primary** Insurance:		
Policy holder's Name:	DOB:	
ID#:	Group #:	
Name of **Secondary** Insurance:		
Policy holder's Name:	DOB:	
ID#:	Group #:	
Who is responsible for payment: Self	Spouse	Other:
EMERGENCY CONTACT		
Name:		
Address:		Phone:
City:	State:	ZIP Code:
Relationship:		
PREVIOUS MEDICAL CARE		
Previous Chiropractic Care: Yes or No	Chiropractor Name:	
HOW DID YOU HEAR OF KIRK CHIROPRACTIC?		
Name:	Source:	

Patient Personal / Confidential Data

••Kirk Chiropractic • Dr. Daren L. Kirk••

Patient's FULL Name: _____ **Date:** _____

Patient's Condition:

1) **Where are you having discomfort? (Neck pain, Hand numbness, Low back pain, etc..)**
   1st Complaint: _____
   2nd Complaint: _____
   3rd Complaint: _____

2) **When did you feel the most recent occurrence/reoccurrence of your complaint if less than 1 month?**
   1st: __Today __#Days Ago __#Weeks Ago _____Date/AM-PM
   2nd: __Today __#Days Ago __#Weeks Ago _____Date/AM-PM
   3rd: __Today __#Days Ago __#Weeks Ago _____Date/AM-PM

3) **What were you doing when you first notice the problem for each complaint?**
   □Auto □On the Job □Unknown □Other(List Below): _____
   _____

4) **On a scale of 0 to 10, 0 being no pain and 10 being the worst pain you've ever experienced, where would you rate your pain? 1st)** _____ (Rate 0-10) **2nd)** _____ (Rate 0-10) **3rd)** _____ (Rate 0-10)

5) **What % of time do you have this discomfort?**
   1st: □Constant(100%) □Frequently(75%) □Occasionally(50%) □Intermittently(25%)
   2nd: □Constant(100%) □Frequently(75%) □Occasionally(50%) □Intermittently(25%)
   3rd: □Constant(100%) □Frequently(75%) □Occasionally(50%) □Intermittently(25%)

6) **Was the onset of discomfort *Sudden* or *Gradual***
   1st: _____
   2nd: _____
   3rd: _____

7) **Since it began, how has the discomfort been?**
   1st: □ Better □ Worse □ Same
   2nd: □ Better □ Worse □ Same
   3rd: □ Better □ Worse □ Same

8) **What aggravates the discomfort(s)?** *Checkmark: the #'s that are aggravated by the action.*
   For example: Does Standing aggravate complaints 1 & 2?: Answer looks like this: ☑1 ☑2 □3:Standing
   □1 □2 □3:**Standing** □1 □2 □3:**Sitting** □1 □2 □3:**Lifting** □1 □2 □3:**Bending**
   □1 □2 □3:**Walking** □1 □2 □3:**Running** □1 □2 □3:**Laying Down** □1 □2 □3:**Turning**

9) **What is DIFFICULT / IMPOSSIBLE to do because of the discomfort(s)?** *Checkmark: the #'s that apply*
   □1 □2 □3:**Sleeping** □1 □2 □3:**Riding** □1 □2 □3:**Household Chores** □1 □2 □3:**Typing**
   □1 □2 □3:**Driving** □1 □2 □3:**Carrying** □1 □2 □3:**Working** □1 □2 □3:**Exercising**
   □1 □2 □3:**Cleaning** □1 □2 □3:**Cooking** □1 □2 □3:**Dressing**
   □1 □2 □3:**A hobby**?(swim, golf, quilting...)_____ □1 □2 □3:**Getting up from a chair**

10) **What are you CURRENTLY doing to relieve the discomfort(s)?** *Checkmark: the #'s that apply*
   □1 □2 □3:**Nothing** □1 □2 □3:**Rest** □1 □2 □3:**Ice** □1 □2 □3:**Heat**
   □1 □2 □3:**Over the Counter/Rx medicine:**_____ □1 □2 □3:**Sitting**
   □1 □2 □3:**Standing** □1 □2 □3:**Other:**_____

11) **What have you done in the PAST to relieve the discomfort(s)?** *Checkmark: the #'s that apply.*
   □1 □2 □3:**Medical Doctor** □1 □2 □3:**Physical Therapy** □1 □2 □3:**OTC/Rx:**_____
   □1 □2 □3:**Other:**_____

12) **How would you describe the discomfort(s)?** *Checkmark: the #'s that apply.*
   □1 □2 □3:**Dull** □1 □2 □3:**Aching** □1 □2 □3:**Burning** □1 □2 □3:**Throbbing** □1 □2 □3:**Sharp**
   □1 □2 □3:**Numb** □1 □2 □3:**Tingling** □1 □2 □3:**Shooting** □1 □2 □3:**Other:**_____

Health Questionnaire

Patient Name: _____ Date: _____

Please Check Mark Each of the Conditions Below that You are Currently Experiencing

MUSCULOSKELETAL SYSTEM
- ☐Low Back Pain
- ☐Mid Back Pain
- ☐Pain Between Shoulders
- ☐Neck Pain
- ☐ Arm Problems: R/L
- ☐Leg Problems: R/L
- ☐Swollen Joints
- ☐Painful Joints
- ☐Sore Muscles
- ☐Weak Muscles
- ☐Walking Problems
- ☐Spasms
- ☐Broken Bones:_____
- ☐Shoulder Pain: R/L
- ☐Wrist Pain: R/L
- ☐Hand Pain: R/L
- ☐Elbow Pain: R/L
- ☐Knee Pain: R/L
- ☐Hip Pain: R/L
- ☐Foot Pain: R/L

EYE, EAR, NOSE & THROAT
- ☐Jaw Pain
- ☐Allergy
- ☐Vision Problems
- ☐Ear Pain
- ☐Ear Noises
- ☐Sinus
- ☐Hearing Loss
- ☐Sore Throat

CARDIOVASCULAR

RESPIRATORY
- ☐Chest Pain
- ☐Difficult Breathing
- ☐Persistent Cough
- ☐Coughing Blood
- ☐Rapid Heartbeat
- ☐Blood Pressure Problems
- ☐Heart Problems
- ☐Lung Problems

Gastro-Intestinal System
- ☐ Poor Appetite
- ☐Excessive Hunger
- ☐Difficulty Chewing
- ☐Difficulty Swallowing
- ☐Nausea
- ☐Abdominal Pain
- ☐Diarrhea
- ☐Constipation
- ☐Black Stool
- ☐Hemorrhoids
- ☐Kidney Trouble
- ☐Liver Trouble
- ☐Gall Bladder Problems
- ☐Weight Trouble

HABITS
- ☐Cigarettes
- ☐Alcohol Abuse
- ☐Coffee or Tea
- ☐Drug Abuse
- ☐_____

NERVOUS SYSTEM
- ☐Numbness
- ☐Depression
- ☐Paralysis
- ☐Dizziness
- ☐Fainting
- ☐Headaches
- ☐Muscle Jerking
- ☐Convulsions
- ☐Insomnia

GENITO-URINARY SYSTEM
- ☐Bladder Trouble
- ☐Urination Problems

FEMALE ONLY
- ☐Vaginal Discharge
- ☐Vaginal Problems
- ☐Lumps on the Breast
- ☐Breast Pain
- ☐Severe Cramps
- ☐Fertility Problems
- ☐Pregnant (Due_____)

Medical History

(Fill in Each Blank, even if answer is "none")

1) **Which conditions do you have a personal history of? (circle)** Arthritis, Cancer, Heart Disease, Diabetes, Asthma, Stroke, other_____.
2) **Which conditions do you have a family history of? (circle)** Arthritis, Cancer, Heart Disease, Diabetes, Asthma, Stroke, other _____.
3) **What Medications are you currently Taking (including OTC):**_____
_____.
4) **What Surgeries have you had (since birth) ?** _____.
5) **Primary Care Doctor**_____ **May Dr. Kirk communicate with them about your care?**_____

Patient Signature (or Parent/Legal Guardian of patient): _____

●●●●●●●●●●●●●●●●DO NOT WRITE BELOW THIS LINE●●●●●●●●●●●●●●●●

Patient Accepted? ☐Yes ☐No **Doctor Signature** _____

Kirk Chiropractic, PC
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Ph: (918) 272-6200 Fax: (918) 274-3724

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**