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 & Wellness Center • Dr. Daren 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 <u>most recent</u> occurrence/reoccurrence of your complaint if less than 1 month?

1st: ___ Today ___ # Days Ago ___ # Weeks Go _____ Date/AM-PM

2nd: ___ Today ___ # Days Ago ___ # Weeks Go _____ Date/AM-PM

3rd: ___ Today ___ # Days Ago ___ # Weeks Go _____ Date/AM-PM

3) What were you doing when you first noticed 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

Kirk Chiropractic & Wellness Center • Dr. Daren Kirk

Patient's FULL 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
- ☐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 Date) _____

Medical History

(Fill in each blank, even if the 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 & Wellness Center

8514 N 128th East Ave Owasso, Ok 74055
(Ph.) 918-272-6200 (Fax) 918-274-3724

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

☐ Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

☐ The practice reserves the right to change the privacy policy as allowed by law.

☐ The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

☐ The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

☐ The practice may decline treatment based upon failure of successful execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____
Witness: _____ Date: _____