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:	

Pediatric Patient Introduction Information

Date: _____

Child's Full Name: _____ Nickname: _____

Child's Date of Birth: ___/___/_____ Age: _____ · Email: _____

Address: _____
(Street) (Apt#) (City) (State) (Zip).

Phone (home) _____ (cell) _____ (work) _____

Names of Parent(s) or Legal Guardian: _____

Name of Primary Insurance: _____ Secondary Insurance: _____

Primary Insured Name: _____ Employer: _____

Previous Chiropractic Care? __Yes __No Chiropractic Doctor's Name: _____

Emergency Contact Name: _____ Ph.No._____ Relationship_____

Who (or what source) referred you? _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Child's Health History:

1) Child's birth was: □At home □At a birthing Center □At a hospital

2) My obstetrician/midwife/family practitioner was _____

3) Child's birth was □Natural vaginal (no medications/interventions)
□Vaginal with interventions:
□Induction □Pain Medication □Epidural □Episiotomy
□Vacuum extraction □Forceps Other:_____
□C-section:
□Scheduled □Emergency

4) Please list reasons for interventions/complications:_____
_____

5) Child's birth weight: _____ Birth height _____
Current weight_____ Current height _____

6) Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime including this year: _____
_____

Pediatric Patient Personal / Confidential Data

●●Kirk Chiropractic ● Dr. Daren L. Kirk●●

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

Patient's Condition:

1) What health condition brings your child to our office?
1st Condition: _____
2nd Condition: _____
3rd Condition: _____

2) When did your child feel the most recent occurrence/reoccurrence of their condition 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 they doing when you first noticed the problem for each condition?
□Auto □Unknown □Other(List Below): _____
_____

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

5) What % of time does your child have 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:**Eating**
□1 □2 □3:**Playing** □1 □2 □3:**Carrying** □1 □2 □3:**A hobby**?(swim, golf, quilting...)_____

10) What are you CURRENTLY doing for your child 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:**Other:** _____

11) What have you done in the PAST to relieve the discomfort(s) for your child?
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) for your child? *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 Your Child is 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
- ☐Lung Problems
- ☐Rapid Heartbeat
- ☐Heart 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

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

GENITO-URINARY

SYSTEM
- ☐Bladder Trouble
- ☐Urination Problems

Other: _____
_____
_____
_____

Medical History

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

1) **Which conditions does your child have a personal history of? (circle)** Ear Infections, Colic, Constipation, Diabetes, Asthma, Allergies, other_____.
2) **Which conditions does your child have a family history of? (circle)** Arthritis, Cancer, Heart Disease, Diabetes, Asthma, Stroke, other _____.
3) **What Medications is your child currently Taking (including OTC):**_____
_____.
4) How many rounds of antibiotics has your child taken in their life? _____.
5) **What surgeries has your child had (since birth) ?** _____.
6) **Primary Care Doctor**_____ **May Dr. Kirk communicate with them about their care?**_____

Signature (Parent/Legal Guardian of patient): _____

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

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

CONSENT FOR TREATMENT OF MINOR

Date _____

I hereby authorize:

Kirk Chiropractic; Dr. Daren L. Kirk, Dr. Nathan Traylor

and whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary to:

Minor Patient's Name	No.
Signature of Parent or Guardian	Date
Witness	Date

Remarks: _____

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: _____