Star Chiropractic Family Clinic, LLC
11644 W. 75th St., ste 102
Shawnee, KS 66214

PATIENT INFORMATION

Please allow our staff to photocopy your driver's license and all available insurance cards.

Full Name_____	Gender: **M F** Height_____ Weight _____
Address:_____	Age_____ Birth Date_____
City:_____State_____Zip___	Email:_____
Home Phone_____Cell_____	Marital Status: **S M W D Sep**. Children_____
Social Security#_____	Spouse Name:_____Phone_____
Work Phone_____ Occupation_____	Spouse's Occupation_____
Employer:_____	Spouse's Employer_____
City_____State_____Zip_____	City_____State____ Zip_____
Do you have health insurance? □ Yes □ No	Does spouse have health Insurance? □ Yes □ No
Plan:_____Group_____	Plan:_____Group_____

Who referred you to our office?

_____

Is your condition due to an accident?
□ No □ Yes Date of Accident_____
If yes was this a -Motor Vehicle □ or
Workers Comp □ Other _____
Have you sought legal counsel? □ No □ Yes
Name:

_____

Phone:

_____

Payment agreement

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Authorization to pay

I (we) hereby authorize and direct payment from any health or motor vehicle insurance company, of any medical/chiropractic expense benefits allowable, to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photo static copy of this agreement shall serve as the original.

Note: 24 hour notice of cancellation is required to avoid a missed appointment charge. Star Chiropractic reserves the right to charge you for any no show, no call.

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various forms of soft tissue manipulation and therapy, on myself (or the patient named below for whom I am legally responsible.) I understand that these procedures will be performed in this office. I am informed that, as in all practices of medicine, in the practice of chiropractic there are some risks to treatment. Although these occurrences are extremely rare, they include but arc not limited to sprains and strains, fractures, disc injuries, vascular accidents, dislocations and general aggravation of inflammatory conditions. I understand that I will have an opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and other procedures. I understand that the doctor will perform a detailed examination in order to minimize any risks. However, I do not expect the doctor to anticipate and explain all risks and complications. Rather, I wish to rely on the doctor's experience and judgment to apply only procedures which are in the best interest of my health and to use the most effective and gentle of those procedures necessary. I have read the above consent. I have discussed it with the doctor and have had my questions answered to my satisfaction. I understand that by not following the prescribed protocol I hold myself responsible for any regressions and/or exacerbations and don't hold the doctor (s) or Star Chiropractic responsible in any form. By signing below, I give consent to the chiropractic care recommended by the doctor. I intend for this consent form to cover the entire course of chiropractic care for my present condition and for any future condition(s) requiring chiropractic care.

Patient Initials:_____

Doctor Initials:_____

Patient's signature_____
(Parent or guardian if applicable)
Date: _____

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Patient Name _____ ***Date***_____

Chief or Primary Complaint--

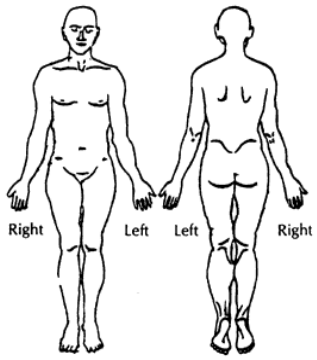
_____

_____

Is this complaint due to a motor vehicle accident or Workmen's Comp? If yes, please explain.

_____

_____



Please mark areas of pain on the drawing.

Circle the severity number 1=least, 10=greatest as of TODAY										
Neck	1	2	3	4	5	6	7	8	9	10
Shoulders/Upper back	1	2	3	4	5	6	7	8	9	10
Arms/ forearms/ hands	1	2	3	4	5	6	7	8	9	10
Middle back	1	2	3	4	5	6	7	8	9	10
Low back/Sacrum/Tail	1	2	3	4	5	6	7	8	9	10
Hips/Knees/Ankles/Feet	1	2	3	4	5	6	7	8	9	10

DESCRIBE YOUR PAIN– circle all that apply

*Burning *Stabbing *Sharp *Shooting *Deep *Dull
*Achy *Throbbing *Intermittent *Constant

Medications currently taking

1._____
2._____
3._____
4._____

Supplements currently taking

1._____
2._____
3._____
4._____

Have you ever had an MRI/CT/MRA: Date taken and reason: _____
_____

Do you exercise: □ Yes □ No Do you sleep well: □ Yes □ No Sleeping position: Back □ Stomach □ Side
Conditions or diseases common among your family members (i.e. inherited diseases): □ Yes □ No
_____

Any diseases you have had in the past, including childhood diseases: _____
_____

Any Hospitalizations or surgery: □ No □ Yes- Describe: _____
_____

Any physical injuries such as whiplash/ concussion/ head injury/ dislocations/ fractures? □ Yes □ No
_____
_____

Do you use: □ Caffeine □ Tobacco □ Nicotine □ Recreational drugs □ Alcohol
Please describe your work: Type □ Professional □ Physical Labor □ Driver □ Clerical □ Factory □ Homemaker
Physical demand: □ Heavy □ Moderate □ Mild □ Sedentary Stress Level: □ High □ Moderate □ Low
Patient Name _____ Date _____

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Have you ever (at any time) been diagnosed with/ or experienced the following?

Unable to urinate or move bowels	Y	N	Shingles/ chicken pox	Y	N
Loss of bladder control	Y	N	Spinal/back/ neck surgery or fractured ribs	Y	N
Loss of bowel control	Y	N	Miscarriages and/or still births	Y	N
Temporary loss of vision, one eye	Y	N	Kidney or Gall bladder stones	Y	N
Blood in urine or bowels	Y	N	Ear Sinus or Throat infections	Y	N
Oral lesions that did not heal	Y	N	Yeast/ Fungal infections	Y	N
Unrelenting migraines	Y	N	Rheumatoid or Gouty arthritis	Y	N
Detached Retina/Increase ocular pressure	Y	N	Ulcerative Colitis/ Celiac's disease	Y	N
Stroke/ Heart attack/ Defective valve	Y	N	Other Colon disease: _____	Y	N
Slipped/ Herniated/prolapsed disc	Y	N	High blood pressure / Low blood pressure	Y	N
High Cholesterol	Y	N	Urinary Bladder disease:_____	Y	N
Osteoporosis including brittle bones	Y	N	Cancer of Kidney, Prostate, Colon, Breast	Y	N
Diabetes including neuropathy	Y	N	Cancer of Uterine, Ovary, Bladder,	Y	N
Fainting spells – syncope	Y	N	Other cancer/tumor: _____	Y	N
Blood clots, aneurysms, or thrombus	Y	N	Ehlers Danlos Syndrome	Y	N
Hemangioma/Cavernous Angioma	Y	N	Hepatitis A B or C	Y	N
COPD/ Asthma/Crest syndrome	Y	N	Lymphadema	Y	N
Prostate problems - BPH	Y	N	Genital Herpes/HPV	Y	N
Digestive issues – GERD or Ulcers	Y	N	Depression or Bipolar	Y	N
Urinary Tract Infec./ Interstitial Cystitis	Y	N	Thyroid problems – hyper or hypo	Y	N
Feet problems – Bunions/hammer toe	Y	N	Orthotics in Shoes	Y	N
Any allergy or immunity problems Y □ N □			Any allergy or immunity problems Y □ N □		
Describe_____			Describe_____		

Please mark any of the following that are applicable to you?

Pregnant at present	Y	N	Receiving hormone therapy	Y	N
Taking birth control pills	Y	N	Surgical/medication implanted devices		
Abnormal periods/menstrual problems	Y	N	Rods, pins, screws	Y	N
On blood thinners- warfarin/coumadin	Y	N	Insulin pumps	Y	N
Hysterectomy (partial or full)	Y	N	Artificial heart valves	Y	N
Weakness in arms or legs	Y	N	Gastric by-pass	Y	N
Balance problems	Y	N	Pacemakers	Y	N
Vertigo (spinning)/ dizziness	Y	N	Shunt/ Stints	Y	N
Recent fever:	Y	N	Neurostimulators	Y	N
Numbness/ sensory complaints	Y	N	Surgical clips/wires	Y	N
Loss of strength or muscle weakness	Y	N	Dentures	Y	N
Double vision/ blurred vision	Y	N	Hearing aids	Y	N
Tinnitus (ringing in ears)	Y	N	Breast implants	Y	N
Speech problems or slurring	Y	N	IUD/ implanon / Mirena	Y	N
Memory loss - forgetfulness	Y	N	Hip Replacement: Left or Right Date:		
Skin rash/infection/eczema/psoriasis	Y	N	Knee Replacement: Left or Right Date		

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Receiving radiation therapy/ chemo Y N

Notes:_____

Patient Name_____Date _____