CONFIDENTIAL
HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.

Today's Date (MM/DD/YYYY)

Required Information:

Last Name | First Name | Middle

Birth Date (MM/DD/YYYY) | Age | ◯ Male ◯ Female

Street Address | City | State | Zipcode

Email Address | Phone Number ◯ Cell ◯ Home

Occupation | Social Security Number

Emergency Contact Name | Emergency Phone Number

Have you ever been to a chiropractor? ◯ Yes ◯ No | Previous Chiropractor

Will you be using any of the following forms of insurance? ◯ Medicare ◯ UHC ◯ Auto Insurance ◯ Worker's Comp

If you are a Medicare patient or an Auto Accident patient, please inform our front desk staff for the additional form before continuing.

Choose One

How did you hear about us? | Whom may we thank for referring you?

Dr. Trevor Hampton
1131 E. North Ave ■ www.beltonchiropractor.com ■ 816.535.5101

The symptom(s) that have prompted me to seek care today include: _____

_____

And, are the result of:
- ◯ An accident or injury ☐ Work ☐ Auto ☐ Other
- ◯ A worsening long-term problem
- ◯ An interest in ☐ Wellness ☐ Other

How extreme are your current symptoms ?

0 ◯◯◯◯◯◯◯◯◯◯ 10

Absent — Uncomfortable — Agonizing

When did you first notice your current symptoms?

_____

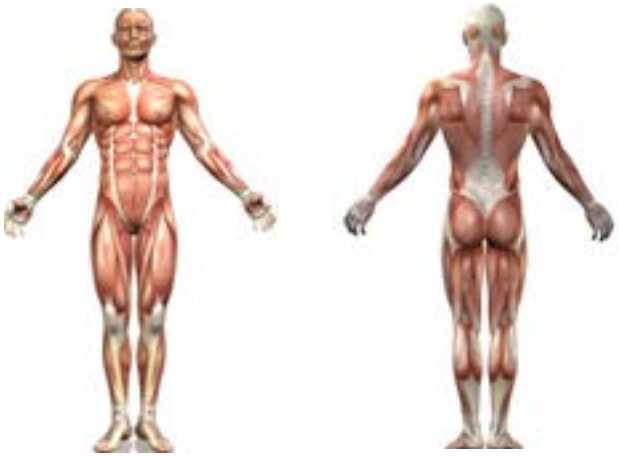
When did it start and how often do you feel it? ◯ Constant ◯ Comes and goes; how often? _____

What does it feel like?

- ☐ Numbness ☐ Burning ☐ Dull
- ☐ Tingling ☐ Shooting ☐ Stabbing
- ☐ Stiffness ☐ Throbbing ☐ Aching
- ☐ Nagging ☐ Cramps ☐ Sharp
- ☐ Other _____

Location (Where does it hurt?)
Circle the area(s) on the illustration

Mark "O" for current condition.
Mark "X" for past condition.



What have you done to relieve the symptoms?

- ☐ Prescription Medication ☐ Heat
- ☐ Over-the-counter drugs ☐ Ice
- ☐ Homeopathic remedies ☐ Massage
- ☐ Surgery ☐ Acupuncture
- ☐ Chiropractic ☐ Physical Therapy
- ☐ Other _____

What tends to worsen the problem? _____

_____

What tends to lessen the problem? _____

_____

Does it affect other areas of your body?/ What areas does the pain radiate, shoot, or travel? _____

_____

Doctor's Notes (please do not write within this space)

1. What else should the doctor know about your current condition?

2. Any other complaints/symptoms with other organ systems? (ex: arthritis, scoliosis, asthma, high cholesterol, headache, TMJ, ulcer, blurred vision, skin cancer, etc)

3. Any prior illnesses? (ex: cancer, diabetes, heart disease, gout, stroke, HIV, etc)

4. What medications are you currently taking (over-the-counter or prescribed)?

5. Any prior operations? (ex: appendix removal, bypass surgery, pacemaker, etc)

6. Any history of injuries? (ex: knocked unconscious, injured in accident, used a neck/back brace, etc)

7. Any relevant family history? (ex: immediate family member (mother/father/sibling/child/grandparent) with history of cancer/ stroke/heart disease, etc)

8. Do you drink alcohol, consume coffee or soda, smoke, exercise regularly, etc?

Need to elaborate any of your answers? Write the number of the question below and explain further:

CONSENT TO CHIROPRACTIC EXAMINATION AND CARE

I, hereby authorize Hampton Chiropractic and its licensed doctors and assistants, based on my complains and the history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I also wish to rely on the Practice doctors to make those decisions about my care, based on the facts then known, that they believe are in my best interest.

The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and to the extent practicable the costs of reasonable alternatives to the proposed treatment.

I have also been advised that although the incidence of complications associated with chiropractic services is very low anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art form medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY) _____

Initials _____ I grant permission to be called to confirm or reschedule an appointment and be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ I have the right to withdraw from or discontinue treatment at any time and that the Practice doctors will advise me of any material risks in this regard.

Initials _____ That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications of an undesirable result does not necessarily indicate an error in judgment or treatment.

Initials _____ My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and proposed course of care and treatments by the Practice.

Date _____ Patient's Printed Name _____ Patient's/Guardian's Signature _____

Relationship to Patient _____

Reset Submit

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