PATIENT PERSONAL/CONFIDENTIAL DATA

Date: _____

Patient: _____ Date of Birth: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Social Security No.: _____ Home Phone: _____ Work/Cell: _____

Email address: _____ May we contact you by email? _____

Employer: _____ Address: _____

Name of Spouse: _____ SS No.: _____ No. of Children: _____

Spouse's Employer: _____ Address: _____

How did you learn of this clinic? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Who is responsible for payment? ( ) Self ( ) Spouse ( ) Other _____

Purpose of this visit & list your complaints: _____

_____

Date of illness: _____ Time: _____ ( ) AM ( ) PM Location: _____

If Accident, please check one:( ) Auto ( ) On the job ( ) Other: _____

Please describe the circumstances and what makes the condition(s) better or worse: _____

_____

_____

_____

Other doctor(s) seen for this condition: _____

Have you been treated by a Doctor for any health condition in the last year? ( ) Yes ( ) No

If yes, please describe: _____

Insurance Information

I understand and agree that health & accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I also authorize this clinic to release any information pertinent to my case to any insurance company, insurance regulatory agency, adjuster, and attorney involved in this case, and hereby release this clinic of any consequence thereof.

Assignment of Benefits

I hereby instruct & direct my insurance company/med-pay carrier/ third party payor or medical expense benefits allowable & otherwise payable to me under my current insurance policy to pay by check made out & mailed directly to Keith G. Ryan Chiropractic PLLC. (Dr. Keith G. Ryan, D.C.) as payment towards the total charges for professional services rendered by this clinic. If I have an HMO (HMO's will only cover care that has been pre-authorized) I understand that if I do not have an authorization, or if the authorization for care is denied, then I agree to be personally & fully responsible for services rendered. A photocopy of this assignment shall be considered as effective and valid as the original.

Consent of Professional Services

I hereby authorize and release the doctor and whomever he-she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case.

Patient Signature: _____ Date: _____

(if parent or guardian, please print name here) _____

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Patient: _____ Date: _____

No.: _____

MUSCULO SKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Spasms
- ❑ Broken bones
- ❑ Shoulder pain

GENITO-URINARY SYSTEM

- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast

ARE YOU PREGNANT?
❑ YES ❑ NO

GASTRO-INTESTIONAL SYSTEM

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Difficult swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting Blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscles jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia

HABITS

- ❑ Cigarettes
- ❑ Alcohol Abuse
- ❑ Coffee or Tea
- ❑ Excercise
- ❑ Drug Abuse
- ❑ _____

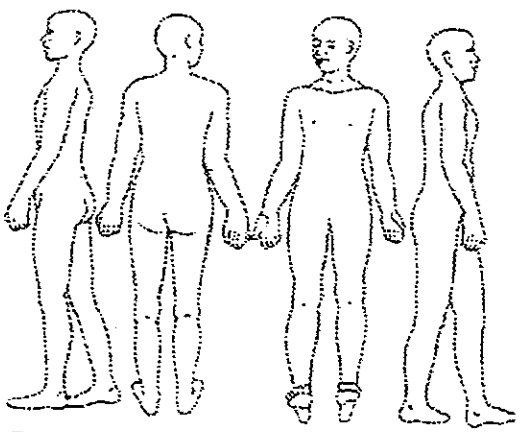
CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficult breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose veins

EYE, EAR, NOSE AND THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficult breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw Pain

SYMPTOM LOCALIZATION



P ___ Pain
N ___ Numb
S ___ Spasm

T ___ Tender
H ___ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

• DO NOT WRITE BELOW THIS LINE •

Patient Accepted? ❑ Yes ❑ No Doctor's Signature _____

Keith G Ryan Chiropractic PLLC

PATIENT CONSENT

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures: We will use and disclose elements of your protected health information (PHI) in the following ways:

Without your signed authorization

- Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services.
- Payment: Your PHI will be used, as needed, to obtain payment for your health care services.
- Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice.
- In emergency situations or to avert serious health/safety situations.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties.
- To organ, tissue, and other donations organizations, upon or proximate to your death, if we have no indication on hand about your donation preferences (or a positive indication)

Special Cases

- To contact you about appointment reminders, treatment alternatives, and other health related benefits and services.
- In fundraising for ourselves
- To the sponsor of your health plan

Other

- All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your right

Restrictions: To request restricted access to all or part of your PHI. To do this, you must request in writing and it must state the specific restriction requested and to whom you want the restriction to apply. If your physician feels it is your best interest to permit use and disclosure of your PHI, we are not required to grant your request.

Confidential Communications: To received correspondence of confidential information by alternate means or location. We will accommodate reasonable requests made in writing.

Access: To inspect or receive copies of your PHI that is contained in a designated record set for as long as we maintain the protected health information.

Amendments: To request changes made to your PHI that is contained in a designated record set for as long as we maintain the protected health information. In certain cases, we may deny your request for an amendment.

This notice: To obtain a paper copy of this notice from us, upon request. I understand that a full and more detailed notice is available to me at any time, located at the front desk.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the practice will not treat me.

I acknowledge receipt of this notice:

Sign_____ Date: _____

Print name of patient: _____

If you are signing as the patient's representative:

Print your name: _____

Describe your authority: _____

ASSIGNMENT OF MEDICAL BENEFITS & INFORMED CONSENT

I understand that my doctor is submitting my x-rays to Midwest Radiology Consultants for radiological evaluation. I also understand that the fee for such services will be submitted to my insurance company, workers' compensation carrier, or my attorney

I authorize my insurance company to pay directly to Midwest Radiology Consultants for services rendered.

In the event my insurance company, attorney, or workman's compensation carrier does not reimburse for the fee in full, or if I do not have insurance coverage, I agree that I am directly responsible for the charges or any unpaid portion. Returned checks for insufficient funds will be assessed a $20.00 service charge. *Accounts delinquent by 90 days from the time of my 1st billing statement may be placed with a legal collection agency. I am fully responsible for all collection costs unless prior payment arrangements have been made with Midwest Radiology Consultants.*

I understand that Dr. Doran L. Nicholson is not a participating provider in my insurance plan and that his services may not be covered by my insurance. *I also understand that this service is not covered by Medicare.*

In the event that my insurance company sends payment directly to me, I agree to promptly remit such payments to Midwest Radiology Consultants.

Patient Signature:

_____

(Patient, Parent or Guardian)

Date: _____

MIDWEST RADIOLOGY CONSULTANTS
706 NE Langsford Rd.
Lee's Summit, MO 64063
Phone: 816 525-2822
800-454-2822
Doran L. Nicholson, D.C., D.A.C.B.R.

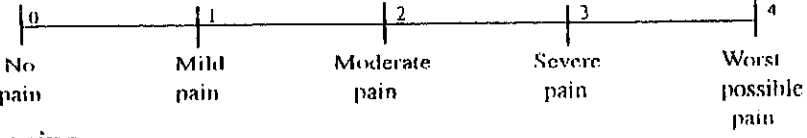
Functional Rating Index

For use with **Neck and/or Back Problems** only.

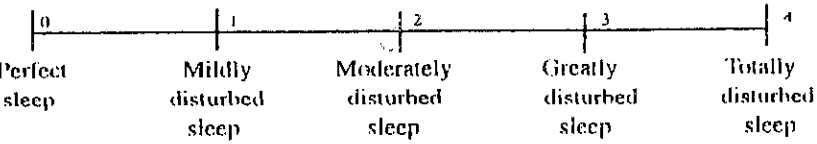
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.

For each item below, **please circle the number which most closely describes your condition right now.**

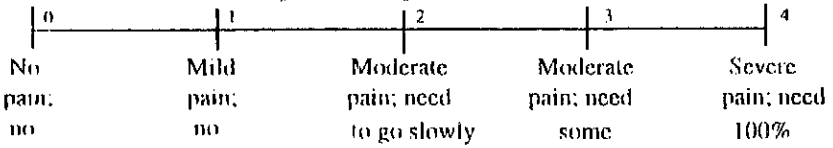
1. Pain Intensity



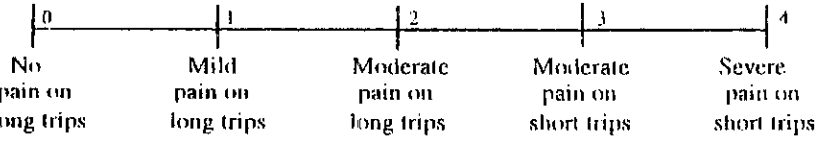
2. Sleeping



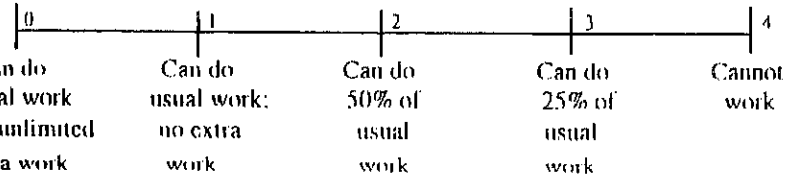
3. Personal Care (washing, dressing, etc.)



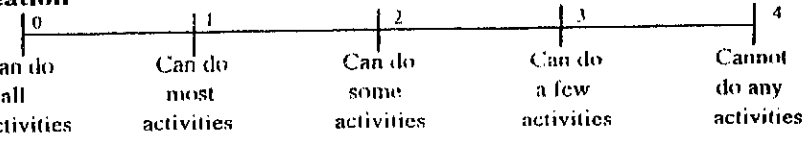
4. Travel (driving, etc.)



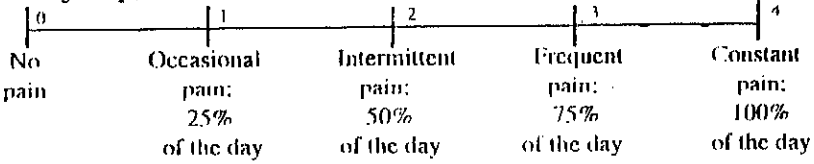
5. Work



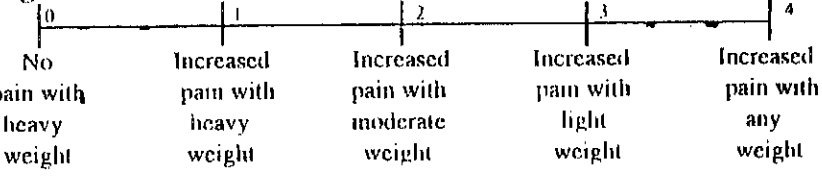
6. Recreation



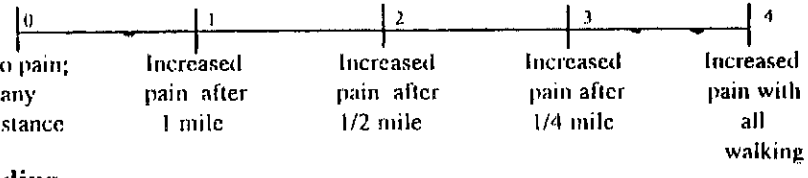
7. Frequency of pain



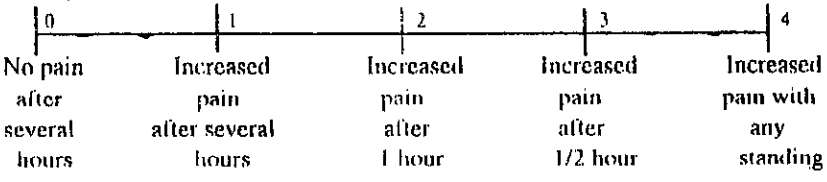
8. Lifting



9. Walking



10. Standing



Name _____

PRINTED

Total Score _____

_____

Signature

_____

Date

PATIENT PERSONAL/CONFIDENTIAL DATA

2014 INFORMATION UPDATE

Date:_____ No._____

Last Name:_____ First Name:_____

Race *(check one)*

☐ White ☐ African American ☐ Native Hawaiian or other Pacific Island

☐ Asian ☐ Japanese ☐ American Indian/Alaskan Nat

☐ Hispanic ☐ Chinese ☐ I choose not to specify

Multi-Racial *(check one)* ☐ Yes ☐ No ☐ Unknown

Ethnicity *(check one)* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I choose not to specify

Preferred Language *(check one)*

☐ English	☐ Spanish	☐ Japanese	☐ French	☐ Hindi
☐ Italian	☐ Vietnamese	☐ Gujarti	☐ Russian	☐ Hebrew
☐ Arabic	☐ Portuguese	☐ Chinese	☐ German	☐ Other_____
☐ Persian	☐ Urdu	☐ Korean	☐ Polish	☐ I choose not to specify

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former smoker ☐ Never been a smoker

List Current Medications you are taking:

If there are no current medications, check here ☐

Medication	Dosage	Frequency
1.		
2.		
3.		
4.		

List Medication Allergies:

If no allergies are known, check here ☐

Medication Allergy	Reaction	Date Began
1.		
2.		
3.		
4.		

Height_____ Weight_____

INFORMED CONSENT

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:
spinal manipulative therapy, palpation, vital signs
range of motion testing, orthopedic testing, basic neurological
muscle strength testing, postural analysis testing
qgm/massage, hot/cold therapy, electrical muscle stimulation
radiographic studies, sEMG testing, and intersegmental traction
Other (please explain)

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____ _____
Patient's Name

_____ _____
Signature

_____
Signature of Parent or Guardian
(if a minor)

Keith G. Ryan Chiropractic PLLC
3319 E. 46th St.
Tulsa, OK 74135