Peak Health

7555 W. 150th street
Overland Park, KS 66223

Phone (913) 685-0950
Fax (913) 685-2941

Whom may we thank for referring you to Peak Health? _____

Patient Demographics

Name: _____ **Date of Birth**_____ **Age**_____ **Male or Female** (Circle)

Address: _____ **City**: _____ **State**: _____ **Zip code**: _____

Home Phone: _____ **Mobile Phone**: _____ **Work Phone**: _____

Fax Number: _____ **E-mail Address**: _____

Social Security #: _____ **Employer**: _____ **Occupation**: _____

Spouse's Name: _____ **Spouse's Employer**: _____

Name and Ages of Children: _____

Emergency Contact Name and Phone Number: _____

Race (circle one) American Indian / Asian / Black or African American / White (Caucasian) / Native Hawaiian / None

Ethnicity (circle one) Hispanic or Latino Not Hispanic or Latino Decline to Answer

Preferred Language: _____

History of Complaint

Please identify the condition (s) that brought you to this office:

Chief complaint: _____ **Third Complaint:** _____

Secondary complaint: _____ **Fourth Complaint:** _____

When did the problem (s) begin? _____ Is your problem the result of ANY type of accident? YES or NO

If yes, identify type of accident: _____ Auto _____Work _____ Home _____ Other (please explain) _____

Date of accident: _____ Approximately what time of day: _____

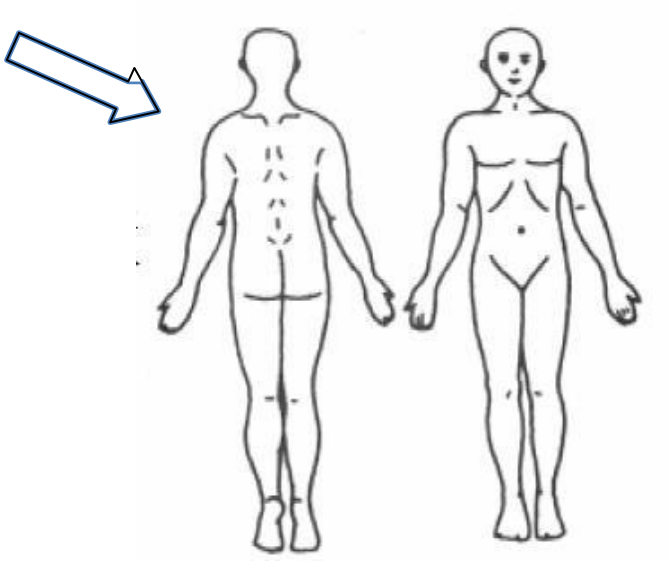
Have you suffered with any of this or similar problems in the past? _____Yes _____ No If yes, how many times? _____

When was the last episode? _____ Other forms of treatment tried? _____

Who provided the treatment? _____ When was the treatment provided? _____

What were the results? _____

PLEASE MARK the areas on the diagram with the following **letters to describe your symptoms:**
R= Radiating B= Burning D= Dull A=Aching
N= Numbness T= Tingling S= Sharp/Stabbing



When is the problem at its worst? _____

How long does it last? _____

What relieves your symptoms? _____

What makes them feel worse? _____

Have you had previous chiropractic care? (circle one) YES or NO

Name of previous chiropractor: _____

How long were you under care? _____ How long ago? _____

What were the results? _____

Rate how you feel today regarding each of your complaints on a scale of 1 to 10 with 10 being the worst pain and 0 being no pain:

	Minimal Pain ⬇									⬇ **Worst Pain I can imagine**
Primary or chief complaint:	1	2	3	4	5	6	7	8	9	10
Second complaint:	1	2	3	4	5	6	7	8	9	10
Third complaint:	1	2	3	4	5	6	7	8	9	10
Fourth complaint:	1	2	3	4	5	6	7	8	9	10

Review of Systems

CIRCLE any symptoms or findings below that you are currently experiencing.

Constitutional: weight loss/gain, fever, chills, trouble sleeping, weakness, or fatigue.

HEENT: visual loss, blurred vision, double vision or yellow sclera, hearing loss, ringing in ears, sneezing, congestion, Sinus/Drainage Problems, runny nose or sore throat.

Skin: No rash or itching.

Cardiovascular: Chest pain, leg swelling, dizziness, or heart palpitations.

Respiratory: Shortness of breath, cough, sputum, wheezing.

Gastrointestinal: trouble swallowing, heartburn, digestive problems, abdominal pain, nausea, vomiting or diarrhea, bloody or black tarry stools

Genitourinary: Incontinence, pain with urination, blood in urine, or urinary frequency.

Neurological: Headache, dizziness, blackouts, paralysis, loss of motor function, numbness or tingling in the extremities. Change in bowel or bladder control. Memory loss or headaches.

Musculoskeletal: Muscle pain/stiffness/cramps, back pain, or joint pain/stiffness.

Hematologic: Anemia, bleeding or bruising, transfusion reactions.

Lymphatics: Any enlarged nodes. History of splenectomy.

Psychiatric: depression, anxiety, mood changes

Endocrine: Cold or heat intolerance, increased urination, thirst, or changes in hunger.

Medical History

Check all that applies:

___ ADHD/ADD	___ Diabetes	___ High Blood Pressure	___Asthma	___COPD
___ Cancer/tumors	___ Seizures	___ Anemia	___Heart Attack	___Stoke
___ HIV/AIDS	___ Hepatitis	___ Ulcers	___ Eating disorder	___Heart mummer
___ High cholesterol	___ Osteoporosis	___ Hyper/Hypo thyroid	___ Scoliosis	___Broken bones
___ Dislocations	___ Sleep disorder	___ Deep Vein Thrombosis (DVT)	___Impotence/Sexual Dysfunction	
___ Learning Disability	___ Rheumatoid Arthritis or Osteoarthritis		___ Bowel or bladder incontinence	

___ Other: _____

Current Prescription and Non-Prescription Medications – May provide printed list instead

_____

_____

Are you Allergic to any Medications? If so, which ones?

_____

Please identify ALL PAST and CURRENT conditions you feel may be contributing to your present problem

Previous Accidents: _____

Injuries: _____

Surgeries: _____

Childhood Diseases: _____

Adult Diseases: _____

Social History

Smoking (circle one) Current Every Day Smoker Occasional Smoker Former Smoker Never Smoked

Alcohol (circle one) Daily Weekends Occasionally Never

Recreational Drug Use (circle one) Daily Weekends Occasionally Never

Do you exercise? ____ Yes ____ No
If yes, what type of exercise and **how often**? _____
Average hours of sleep _____ How many 8 oz glasses of water do you drink per day _____
Circle what kind of diet are you on: heart healthy, diabetic, gluten free, regular, low sodium, other: _____
Hobbies/Interest _____
Has your hobbies/Interest been affected; if so how?
_____
_____
_____

Family History

Does anyone in your family suffer with the same condition (s)? (circle one) Yes No

If yes, whom?_____

Any other hereditary conditions that the doctor should be aware of? (circle one) Yes No

If yes, what conditions? _____

Females Only - Pregnancy Release

This is to certify that to the best of my knowledge that I am not pregnant and the above doctor and his/her associates have my permission to perform and x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Patient Signature: _____Date: _____

All Patients

Would you like a receipt of your clinical summary after each visit? (circle one) Yes No

Patient or legal guardian signature:_____ Date: _____

Doctor's Signature: _____ Date: _____

Nurse Practioner's Signature: _____ Date: _____

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Peripheral Vascular Disease Screening Questionnaire

Peripheral Vascular Disease (PVD) is a common circulatory problem in which vessels carrying blood to the extremities are not functioning well or becoming narrowed or clogged due to a build-up of plaque.

Fill out the questionnaire so your physician can evaluate whether you may be at risk or have symptoms of peripheral vascular disease.

Please circle "YES" or "NO" on the following questions and check all boxes that apply:

Have you ever been diagnosed with peripheral vascular disease or been diagnosed as having poor circulation? YES NO	IF you have pain, does the pain subside with rest? YES NO
Have you ever had surgery, balloon procedures, or stents in your heart, kidneys, stomach, legs or arms? YES NO	Do your feet or toes bother you most nights while lying in bed, with relief when they are dangled at the edge of the bed? NO YES
When you walk, do you experience aching, cramping or pain in your arms, legs, thighs, or buttocks? YES NO	Do you have any painful sores or ulcers on legs or feet that do not heal? YES NO
If you answered YES to the question above, when do you feel the pain: ❑ After walking 1 block ❑ Climbing a flight of stairs ❑ After walking 100 yards ❑ Walking at increased speed	Check all that apply: ❑ I am a current smoker ❑ I have a history of smoking ❑ I have diabetes ❑ I have a family history of diabetes ❑ I have high cholesterol ❑ I have a family history of high cholesterol ❑ I have high blood pressure/hypertension ❑ I have a family history of high blood pressure/hypertension ❑ I have coronary artery disease ❑ I have a family history of coronary artery disease ❑ I have had a stroke/mini-stroke/TIA ❑ I have a family history of stroke/mini-stroke/TIA
Are your legs or arms pale, discolored or bluish? YES NO	_____ **Patient Signature**

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Vascular / NCV Screening Questionnaire

Please check the appropriate response

Yes or No

1. Are you over the age of 35? _____
2. Have you ever suffered from headaches? _____
3. Do you have a family history of cardiovascular disease? _____
4. Do you have high blood pressure? _____
5. Do you suffer from dizziness or light-headedness? _____
6. Do you have a history of smoking? _____
7. Have you ever experienced tingling or numbness in your legs or arms? _____
8. Do you bruise easily? _____
9. Do you get easily or feel fatigued after common physical activity? _____
10. Do you have a stressful lifestyle? _____
11. Do you exercise regularly? _____
12. Do you get at least 7 hours of sleep nightly? _____
13. Do you eat three balanced meals a day? _____
14. Do you take birth control? _____
15. Do you have varicose veins? _____
16. Do you suffer from Diabetes? _____
17. Do you have any swollen or stiff joints? _____

Patient Name:_____

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Financial Policy

Dear Patient,

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. By signing this agreement, you understand that you are responsible for all charges during your treatment regardless of any insurance coverage. We will file your insurance if available but it is not a guarantee of payment so you are ultimately responsible for your entire bill. From time to time your insurance company may require information from you. Please return all forms back to them as soon as possible. Delaying this will cause your claims to be denied. If needed information is not returned, you could be totally responsible for your bill. We will do all we can to help get your claims paid but often your help is required too. Please keep in mind that sometimes it takes weeks or months to process delays in and out of our office. We do accept cash, checks, debit and credit cards for your convenience. We ask that all co-pays be paid at the time of your visit. Deductible and co-insurance amounts will be discussed at the time of your visit.

"I have read, understand and agree to all provisions of this policy."

_____ _____
Signature of patient or legal guardian Date

HIPAA Policy

By signing below, you acknowledge that you understand the rules and guidelines of HIPAA and agree to adhere to them.
**If you wish to be given a copy of the HIPAA policy, please ask the front desk.*

_____ _____
Signature of patient or legal guardian Date

Medical Records Release

I give permission for the following persons to have full access to my medical records.

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship