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.
Please Print Clearly.

Dr. Lennon Kirkendall
131 West Blue Starr Drive
Claremore, OK 74017
(p) 918.283.4355 (f) 918-283-4357
www.kirkendallchiropractic.com

Name **Today's Date**

Date of Birth **Age** **Gender** (□ Male □ Female) **Social Security #**

Address

City **State** **Zip**

Home Phone **Cell Phone** **Work Phone**

Email

Occupation **Employer**

Employer's address

City **State** **Zip**

Marital Status (□Married □Single □Divorced □Widowed)

Spouse's Name **Phone**

Emergency Contact **Phone**

Whom may we thank for referring you?

Insurance Carrier **Policy Number**

Who carries this policy? (□Self □Spouse □Parent) (if spouse or parent please complete the insured's information below)

Insured's Name **Date of Birth**

Insured's Employer **Phone**

Address

City **State** **Zip**

Primary Care Physician **Phone**

Have you consulted a chiropractor before? □Yes □No If so, when? _____

Describe the symptoms that have prompted you to seek care today _____

Are these symptoms the result of:

□An accident or injury — Date of Accident _____

□Work related — State in which it occurred _____

□Auto accident

□Other injury

□A worsening long-term problem

□An interest in wellness

□Other _____

Have you had similar conditions in the past? □ Yes □ No

Have you been treated by another provider (ex: MD, PT, Nutritionist) for this condition?

□ Yes □ No Type of treatment received: _____

Onset (When did you first notice your symptoms?) _____

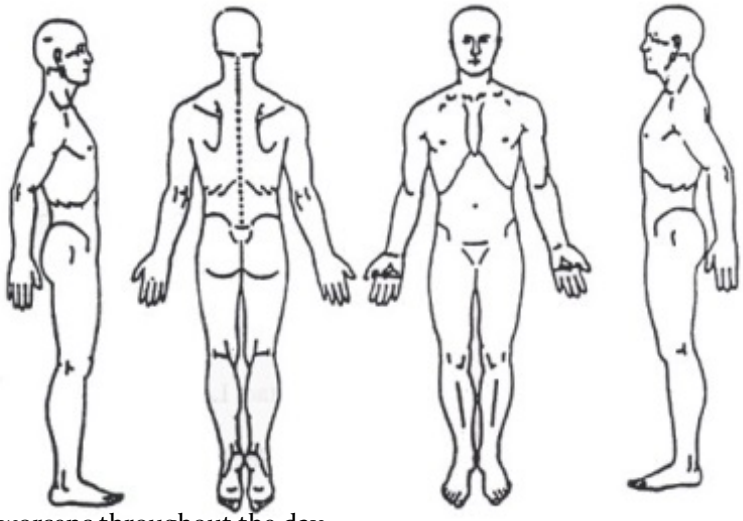
Intensity (How extreme are your current symptoms?)

(absent) □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 (agonizing)

Quality of symptoms (What does it feel like?)

□ Dull
□ Ache
□ Sharp/Stabbing
□ Burning
□ Numbness
□ Tingling
□ Stiffness
□ Throbbing
□ Weakness
□ Other _____

Location (Mark the areas of the symptoms you are experiencing)



Duration/Timing (How often do you feel it?)

□ Comes and goes □ Constant
□ Getting worse □ Progressively worsens throughout the day

Aggravating or relieving factors (Such as time of day, movements, certain activities, ice/heat, etc.)

What tends to make the problem worse? _____

Does anything tend to lessen the problem? _____

Prior interventions:

□ Prescription medication □ Ice □ Massage
□ Over-the-counter medication □ Heat □ Other _____

Does your current condition interfere with your:

□ Work □ Household responsibilities □ Sleep
□ Recreational activities □ Personal relationships □ Other _____

Do you have pain when:

□ Coughing □ Sneezing □ Laughing □ Going to the bathroom

Do you have difficulty controlling your bowels or bladder? □ Yes □ No

List any additional details Dr. Kirkendall should know about your current condition

_____

Review of Systems/Health History

(Indicate if you have these conditions Now or if you've had them in the Past)

Constitutional
- □ Fainting
- □ Fatigue/Low Energy
- □ Fever/Chills
- □ Loss of Appetite

Musculoskeletal
- □ Arthritis
- □ Gout
- □ Joint Replacement
  location: _____
- □ Joint Stiffness
- □ Muscle Weakness
- □ Osteoporosis
- □ Scoliosis

Cardiovascular
- □ Aortic Aneurysm
- □ Arteriosclerosis
- □ Chest Pain
- □ Congestive Heart Failure
- □ Coronary Artery Disease
- □ Heart Attack
- □ High Blood Pressure
- □ High Cholesterol
- □ Irregular Heartbeat
- □ Pacemaker
- □ Stroke

Endocrine
- □ Diabetes
- □ Thyroid Disorder

Other: _____

Respiratory
- □ Allergies
- □ Asthma
- □ COPD
- □ Emphysema
- □ Frequent Cold or Flu
- □ Pneumonia
- □ Sleep Apnea
- □ Tuberculosis

Digestive
- □ Constipation
- □ Diarrhea
- □ Food Sensitivities
- □ Gallbladder Issues
- □ Heartburn/Acid Reflux
- □ Liver Problems
- □ Nausea/Vomiting
- □ Ulcer

Neurological
- □ Brain Aneurysm
- □ Epilepsy/Seizures
- □ Head Injury
- □ Headaches/Migraines
- □ Multiple Sclerosis

Psychiatric
- □ Anxiety Disorders
- □ Depression
- □ Insomnia
- □ Unusual Stress

Genitourinary
- □ Burning with Urination
- □ Frequent Urination
- □ Kidney Disease
- □ Kidney Stones
- □ Sexually Transmitted Disease

Hematologic/Lymphatic
- □ Anemia
- □ Bleeding Disorders
- □ Blood Clot/DVT
- □ Cancer
  type: _____
- □ Excessive Bruising
- □ Hepatitis
- □ HIV/AIDS

Skin
- □ Acne
- □ Eczema
- □ Hair Loss
- □ Psoriasis
- □ Rashes

Eyes/Ears/Nose/Throat
- □ Glaucoma
- □ Blurry Vision
- □ Dizziness
- □ Hearing Loss
- □ Ringing in Ears
- □ Loss of Smell
- □ Frequent Nosebleeds
- □ Difficulty Swallowing

Men's Health History

Have you had any Prostate problems? □ Yes □ No Date of last PSA test? _____

Women's Health History

Total number of pregnancies: _____ Number of births: _____ Date of last menstrual period: _____

Surgeries and Hospitalizations

(Please use a separate piece of paper if more space is needed)

Surgery/Hospitalization	Date	Reason/Diagnosis

Accidents and Injuries

(Please indicate if you've had any of the following)

□ Fractured/Broken bone □ Injured in an accident □ Been knocked unconscious □ Had a sprain/strain

Medications

(Please include both prescription and over-the-counter medications)

_____

_____

_____

Current Height _____ **Weight** _____

Social History (Please tell us about your health habits)

Do you exercise regularly? □ Yes □ No How often? _____

How would you rate your diet? □ Good □ Fair □ Poor Would you like advice? □ Yes □ No

Do you consume caffeine daily? □ Yes □ No Servings/day _____

Do you drink alcohol on a regular basis? □ Yes □ No Servings/day _____

Do you smoke or use tobacco products? □ Yes □ No Packs/day _____

Have you smoked in the past? □ Yes □ No When did you quit? _____

Do you use recreational drugs? □ Yes □ No What type? _____

Have you used IV drugs in the past? □ Yes □ No

Family History (Some health issues are hereditary. Please tell us about the health of your immediate family members.)

Relationship	**Age** (if living)	**Medical Conditions**	**Age at Death**
Mother			
Father			
Sister			
Brother			

Acknowledgements

Informed Consent and Authorization for Treatment

I instruct the chiropractor and/or anyone working in this office authorized by the chiropractor to deliver any chiropractic, diagnostic, or therapeutic treatment on me (or on the patient named, for whom I am legally responsible: _____) that, in her professional judgement, can best help me in the restoration of my health and is deemed necessary or advisable.

I understand and am informed that, as with any healthcare procedure, results are not guaranteed and 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, strokes (CVA), and burns. Some patients will feel some stiffness and soreness following the first few days of treatment. Fractures are rare occurrence and generally result from some underlying weakness of the bone which will be checked for during examination. 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. 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. I understand every reasonable effort will be made during the examination to screen for contraindications to care; however, I do not expect the chiropractor to be able to anticipate and explain all risks and complications.

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 from medicine and does not proclaim to cure any named disease**. I have read □, or have had read to me □,** the above consent. By signing below, I agree to the treatment recommended by my chiropractor. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstance.

Initials _____

Disclosure of Information

I understand that my personal health records and billing information are made and retained by Kirkendall Chiropractic PLLC and are accessible to office personnel. This Practice is authorized to use and disclose all or part of my personal health record to any insurance carrier, worker's compensation carrier, or self-insured employer group liable for any part of the Practice's charges and to any health care provider who is or may become involved in my continuum of my care. Oklahoma law requires that this Practice advise you that the information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease, or related to mental health, or drug, substance or alcohol abuse. By signing this agreement, you are consenting to such disclosure. Practice personnel may release my general condition to family or friends who inquire about me by name.

Initials _____

Assignment of Insurance Benefits and Financial Responsibility

I agree that insurance benefits otherwise payable to the insured are to be made payable to Kirkendall Chiropractic PLLC and/or to the physician responsible for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. I acknowledge that any insurance I may have is an agreement between the carrier and myself and that I am responsible for the payment of all covered or non-covered services I receive, regardless of insurance coverage. Charges for services and goods shall be at Kirkendall Chiropractic PLLC's billed charge rates unless otherwise agreed to in writing by Lennon Kirkendall, DC. I also understand that if I suspend or terminate my schedule of care as determined by the chiropractor, any fees for professional services will be immediately due and payable.

Initials _____

X-ray

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: _____

Initials _____

Certification

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction. I further certify that, 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 am the patient or duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect has an original.

Initials _____

Acknowledgement of Notice of Privacy Practices

A complete description of how your medical information will be used and disclosed by Kirkendall Chiropractic PLLC is in our NOTICE OF PRIVACY PRACTICES, which you have received. A copy is posted in this Practice. I have received a copy of Notice of Privacy Practices.

Initials _____

Patient or Patient's Legal Representative	Relationship to Patient	Date Signed	Witness