244 E US Hwy 69, Suite 202
Kansas City, MO 64119
P 816.453.1198 * F 816.453.0381
www.ahckc.com E-Mail: info@advancedhealthchiro.com
Dr. Cheryl Golladay and Dr. Noelle Van Meter

PATIENT NAME: _____ DATE: _____

Chiropractic Case History/Patient Information

Name: _____ Social Security # _____

Age: ____ Birth date:_____ Marital: M S W D

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ (Note: Your email address will remain private and will only be used to send AHC specials, health tips, e-Cards and office news. You can unsubscribe anytime using the link at the bottom of every email. You will receive an opt-in email to confirm your approval.)

Home Phone: _____ Cell Phone: _____

Can we leave a message on both of the #'s listed above? □ Yes □ No

Occupation:_____ Employer: _____

Spouse: _____ Occupation/Employer:_____

Emergency Contact: _____ Phone: _____

How were you referred to our office?

Referral, if so who can we thank? _____ Insurance Directory

Online Search Yellow Pages Signage Facebook Twitter Other : _____

Family Medical Doctor? _____ Do we have you permission to inform your doctor regarding your care at this office? _____

History of Present Illness:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or date of accident: _____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or similar condition? □ Yes □ No If yes, when and describe:

_____

_____

How did you treat it? _____ Date of last physical exam? _____

What do you hope to get out of your Chiropractic visit(s)? _____

Past Medical History:

Do you have skin hair or nail problems?	No	Yes	
Do you have mouth and/or throat problems?	No	Yes	
Do you have nose and/or sinus problems?	No	Yes	
Do you have ear problems?	No	Yes	
Do you have eye problems?	No	Yes	
Do you have chest or lung (breathing) problems?	No	Yes	
Do you smoke?	No	Yes	Cigarettes per day? How Long?
Do you drink alcoholic beverages?	No	Yes	Per week?
Do you have heart and/or blood vessel problems?	No	Yes	
Do you have blood or lymph node problems?	No	Yes	

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ADVANCING YOUR HEALTH NATURALLY

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Do you have digestive problems?	No	Yes	
Do you have genital problems? (prostate/vagina)	No	Yes	
Do you have urinary, kidney or bladder pblms?	No	Yes	
Have you been physically abused?	No	Yes	
FEMALE			
Have you had menstrual problems?	No	Yes	
Have you ever taken birth control pills?	No	Yes	
Is there any chance you are currently pregnant?	No	Yes	
Do you have breast problems?	No	Yes	
ALL PATIENTS			
Do you have any nervous system disease?	No	Yes	
Have you had any seizures/convulsions?	No	Yes	When?
Do you have any mental health problems?	No	Yes	
Do you have any gland and/or hormone pblms?	No	Yes	
Do you have any allergy or immunity problems?	No	Yes	
Do you have muscle, tendon or ligament pblms?	No	Yes	
Do you have any bone or joint disease?	No	Yes	
Do you have any problems with recurring HA?	No	Yes	
Are you losing weight without trying?	No	Yes	
Does your pain wake you up at night?	No	Yes	
Have you had a change in bowel/bladder habits?	No	Yes	
Have you had a sore that doesn't heal?	No	Yes	
Have you had any unusual bleeding or discharge?	No	Yes	
Do you have a lump in the breast or elsewhere?	No	Yes	
Do you have indigestion or difficulty swallowing?	No	Yes	
Have you had an obvious change in a wart/mole?	No	Yes	
Do you have a nagging cough/hoarseness?	No	Yes	
HAVE YOU EVER EXPIERIENCED:			
Difficulty urinating?	No	Yes	
Loss of bladder control?	No	Yes	
Loss of bowel control?	No	Yes	
Temporary loss of vision, eye?	No	Yes	
Blood in urine?	No	Yes	
Claustrophobia?	No	Yes	
Spinal Surgery?	No	Yes	
Common cold/flu?	No	Yes	
Carotid artery surgery?	No	Yes	
Breast removal?	No	Yes	
Forceps Delivery?	No	Yes	
Childhood accidents/broken bones/falls?	No	Yes	
HAVE YOU EVER BEEN DIAGNOSED WITH:			
Detached retina?	No	Yes	
Stroke?	No	Yes	
Slipped disc?	No	Yes	
Herniated disc?	No	Yes	
Osteopenia or Osteoporosis?	No	Yes	
TIA's (mini stroke)	No	Yes	
Drop attack (collapsing but not fainting)	No	Yes	
Hardening of the arteries?	No	Yes	
Partial or complete paralysis?	No	Yes	
Rheumatoid arthritis?	No	Yes	
Fractured/broken vertebrae?	No	Yes	Where?
Fractured/broken bones?	No	Yes	
Eating Disorder?	No	Yes	
Alcoholism and/or Drug addiction?	No	Yes	
Bleeding disorders?	No	Yes	
Nervous system disorders?	No	Yes	
High blood pressure?	No	Yes	
Blood in stool?	No	Yes	
Cancer?	No	Yes	
AIDS?	No	Yes	
Kidney disease?	No	Yes	

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Prostate disease?	No	Yes	
IN THE PAST MONTH HAVE YOU EXPERIENCED:			
Nausea?	No	Yes	
Vomiting?	No	Yes	
Vertigo?	No	Yes	
Difficulty walking?	No	Yes	
Lack of coordination?	No	Yes	
Headaches or migraines?	No	Yes	
Loss of consciousness?	No	Yes	
Double vision?	No	Yes	
Blurred vision?	No	Yes	
Tinnitus?	No	Yes	
Speech problems?	No	Yes	
Clumsiness?	No	Yes	
Memory loss?	No	Yes	
Personality changes?	No	Yes	
Fever?	No	Yes	
Diarrhea?	No	Yes	
Loss of strength?	No	Yes	
Head trauma?	No	Yes	

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (including dates):_____

_____

What medications and/or supplements are you taking?_____

_____

Do you have any general allergies or any to medications or latex? □ Yes □ No If yes, describe

_____

Is there anything you feel we should know about you &/or your condition?_____

_____

Social History:

Do you consume caffeine? _____ If so, how much per day _____

Do you exercise? ____ If yes, what is the frequency and type of exercise?_____

What percentage of time during the day (at home or at your job) do you spend

Lifting _____ Sitting _____ Bending _____ Working at at computer _____

Family History

Parents:

Father: Living___ Deceased___ Current age if living: ____ Cause of death and age at death if deceased: _____

Mother: Living___ Deceased___ Current age if living: ____ Cause of death and age at death if deceased: _____

If applicable: ____ Adopted as a child, little is known of birth parents or family.

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Family Diseases (check if applicable, indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother)

Tuberculosis___ Cancer___ Mental Illness___ Diabetes___

Asthma___ Heart Disease___ Stroke___ Kidney Disease___

Lung Disease___ Arthritis___ Liver Disease___ Other_____

Please check any and all insurance coverage that may be applicable in this case:

□ Major Medical □ Workers Compensation □ Medicare □ Auto Accident

□ Medical Savings Account & Flex Plan □ Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

Dr. Cheryl Golladay DC, Dr. Noelle Van Meter DC, Advanced Health Chiropractic

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have had the opportunity to request a copy of the HIPPA NOTICE before signing this consent and understand and agree with how my records will be used and agree to these policies and procedures.

Patient Signature_____ Date _____

Advanced Health Chiropractic
FINANCIAL POLICY

CASH PATIENTS: Patients without the benefit of chiropractic coverage on their insurance are **responsible to pay 100%** of their charges as services are rendered. If care becomes extensive, a **payment agreement** can be provided which will spell out a monthly amount.

GENERAL INSURANCE: As a courtesy to you we will bill your insurance company and wait for payment. The insured is responsible for knowing their insurance benefit coverage. Every attempt will be made to determine an estimate of the insured's coverage, but because the insurance policy is a unique agreement between your employer and the insurance company, **we can make no guarantees**. **We cannot become involved in disputes between you and your insurance company** regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered services, coinsurance, coordination of benefits, pre-existing conditions or "reasonable and customary charges", etc., other than to supply factual information when necessary. Each guest is ultimately responsible for the timely payment of their account.

Your obligation is to pay any and all deductibles and co-payments as you go. **You are also responsible for any "non-covered" services. If your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim and after 90 days you will be responsible for payment in full for any outstanding balance. Remember, the care and services were provided to *you* and not your insurance company. You are responsible for all cost incurred in this office.**

MEDICARE: As a participating provider with Medicare, we will accept what Medicare approves for your adjustments. Please be aware that **Medicare covers only chiropractic adjustments**. Medicare does not pay for any other services performed at our office, including but not limited to the New Patient Exam.

WORKERS COMPENSATION: It is your responsibility to provide all necessary billing information to this office before or the day of your initial visit. If you have retained an attorney, you are also further required to provide this office with all attorney information. If you are a Missouri Workers Compensation patient, the laws require you, to get your employer's approval to come to this office. Without this approval, Missouri Workers Compensation will not pay for your care.

PERSONAL INJURY: All patients involved in a personal injury, such as a motor vehicle accident, are required to provide all necessary billing information and attorney information to this office before or the day of your initial visit. If you have retained an attorney you will be asked to sign a lien to protect any outstanding balance in this office at the time of settlement. **Any outstanding balance not paid at the time of settlement is YOUR responsibility.**

CANCELLATION/NO SHOW POLICY FOR APPOINTMENTS: We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
First No Call/No Show - $0
Second (and beyond) No Call/No Show - $25 fee; this will not be covered by your insurance company.

COLLECTIONS FEE: If your account goes 90 days + with no payment and payment arrangements are not made your account will be sent to collections and a $25 fee will be added to cover costs.

I understand the information above and agree to the financial policy

PATIENT SIGNATURE: _____
PRINTED NAME: _____
DATE: _____

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