Fox Chiropractic Clinic
1004 Lincoln Ave. Wamego KS 66547

New Patient Information

Jerry W. Fox, D.C.
785-456-8657
FoxChiropracticClinic.com

Patient: _____ **Patient #** _____ **Date:** _____

Address _____ City _____ State _____ Zip Code _____
H. Phone #_____ W. Phone #_____ Cell Phone #_____
Email Address: _____ Social Security # _____ Marital Status S M W S D
Gender M F Date of Birth _____ Age ____ Weight _____ Height _____ Race/Ethnicity _____
Occupation:_____ Employer: _____
Job duties: _____
Spouse's name: _____ Date of Birth: _____ Social Security # _____
Spouse's Employer: _____ W. Phone # _____
Nearest friend/relative not living with you: _____ Phone #_____
Physician: _____ Referred by: _____

****

Reasons for seeking chiropractic care:

Primary reason: _____
Problem started on _____ Is this a result of an accident? Y N If yes, when _____

Secondary reason:_____
Problem started on _____ Is this a result of an accident? Y N If yes, when _____

More details questions about your current condition(s) will be asked later.

Previous treatments, medications, surgery, or care you've sought for your current symptom(s):

_____
_____
_____

Have you ever received Chiropractic Care for this or another condition? Yes No If yes, when?_____
Chiropractor:_____ Condition treated: _____

****

Current and Past Health History:

Current or Previous major Injuries or Trauma:

Have you had any broken bones? Y N When:_____ What:_____
Past auto accidents: Y N When:_____ How bad? _____
Other:_____

Surgeries:

Date:	Reason for surgery and outcome:
_____	_____
_____	_____
_____	_____

Issues that may be of concern or affect your ability to receive chiropractic care.
Please indicate if the following issues are C = constant, F = frequent, O = occasional, P = past problem.

C F O P	C F O P	C F O P	C F O P
□□□□ Arthritis	□□□□ Degenerative disc disease	□□□□ Implant / pace maker	□□□□ Stroke / TIA's
□□□□ Cancer	□□□□ Dizziness/vertigo	□□□□ Knee replacement	□□□□ Seizures
□□□□ Cervical whiplash	□□□□ Fibromyalgia	□□□□ Multiple sclerosis	□□□□ Shoulder issues L R
□□□□ Compressed vertebra	□□□□ High blood pressure	□□□□ Numbness of the face/arm	□□□□ Spinal fusion
□□□□ Disc herniation	□□□□ Hip replacement	□□□□ Osteoporosis	□□□□ Tumors

□□□□ Other important issue:_____
□ None of the above

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Review of the Systems of the Body: Have you had any of the following? (Indicate if C = constant, F = frequent, O = occasional, P = past)

Neurological

C F O P (nerve-related)
☐☐☐☐ Chronic fatigue
☐☐☐☐ Decreased sense of smell
☐☐☐☐ Decreased sense of taste
☐☐☐☐ Difficulty sleeping
☐☐☐☐ Epilepsy
☐☐☐☐ Hearing loss
☐☐☐☐ Memory loss
☐☐☐☐ Numbness in part of body
☐☐☐☐ Parkinson's disease
☐☐☐☐ Severe headaches
☐☐☐☐ Tremors
☐☐☐☐ Visual change
☐☐☐☐ Weakness in part of body
☐☐☐☐ Other:_____
☐ All normal

Endocrine

C F O P (hormonal-related)
☐☐☐☐ Brittle finger/toe nails
☐☐☐☐ Diabetes
☐☐☐☐ Enlarged glands, nodes
☐☐☐☐ Hair loss / falling out
☐☐☐☐ Hormone therapy
☐☐☐☐ Thyroid issues
☐☐☐☐ Other:_____
☐ All normal

Psychological

C F O P (mental issues)
☐☐☐☐ Anxiety
☐☐☐☐ Bipolar disorder
☐☐☐☐ Depression
☐☐☐☐ Chemical dependency
☐☐☐☐ Psychiatric diagnosis
☐☐☐☐ Psychiatric hospitalization
☐☐☐☐ Suicidal indications
☐☐☐☐ Schizophrenia
☐☐☐☐ Other:_____
☐ All normal

Cardiovascular

C F O P (heart-related)
☐☐☐☐ Angina / chest pain
☐☐☐☐ Cold hands / feet
☐☐☐☐ Congestive heart failure
☐☐☐☐ Heart attack
☐☐☐☐ Heart disease
☐☐☐☐ Heart surgery
☐☐☐☐ Irregular heartbeat
☐☐☐☐ Pacemaker
☐☐☐☐ Murmur
☐☐☐☐ Swelling ankles / hands
☐☐☐☐ Varicose veins
☐☐☐☐ Other:_____
☐ All normal

Renal

C F O P (kidney-related)
☐☐☐☐ Bladder infections
☐☐☐☐ Diabetes
☐☐☐☐ Dialysis
☐☐☐☐ Difficult / painful urination
☐☐☐☐ Enuresis (Bed wetting)
☐☐☐☐ Gout
☐☐☐☐ Hematuria (blood in urine)
☐☐☐☐ Incontinence
☐☐☐☐ Kidney disease
☐☐☐☐ Kidney stones
☐☐☐☐ Prostrate issues
☐☐☐☐ Other:_____
☐ All normal

Dermatological

C F O P (skin-related)
☐☐☐☐ Psoriasis
☐☐☐☐ Shingles
☐☐☐☐ Significant burns
☐☐☐☐ Significant rashes
☐☐☐☐ Skin allergies
☐☐☐☐ Other:_____
☐ All normal

Hematological

C F O P (blood-related)
☐☐☐☐ Abnormal bleeding/bruising
☐☐☐☐ Anemia
☐☐☐☐ Blood clots
☐☐☐☐ Blood thinner medication
☐☐☐☐ Leukemia
☐☐☐☐ Vitamin injections
☐☐☐☐ Other:_____
☐ All normal

Gastroenterological

C F O P (Stomach-related)
☐☐☐☐ Bloody or black stools
☐☐☐☐ Celiac disease
☐☐☐☐ Constipation
☐☐☐☐ Colitis
☐☐☐☐ Diarrhea
☐☐☐☐ Food allergies
☐☐☐☐ Frequent abdominal pain
☐☐☐☐ Frequent gas or bloating
☐☐☐☐ Gallbladder issues
☐☐☐☐ Hemorrhoids
☐☐☐☐ Hepatitis
☐☐☐☐ Hiatal hernia
☐☐☐☐ Irritable bowel
☐☐☐☐ Liver disease
☐☐☐☐ Nausea
☐☐☐☐ Pancreatic disease
☐☐☐☐ Reflux or heartburn
☐☐☐☐ Ulcers
☐☐☐☐ Other:_____
☐ All normal

Females only

C F O P (female issues)
☐☐☐☐ Brest tenderness
☐☐☐☐ Excessive Cramps
☐☐☐☐ Hot flashes
Have you had a hysterectomy? Yes No If yes, when _____
Are you pregnant? Yes No If yes, due date_____

Pulmonary

C F O P (lung-related)
☐☐☐☐ Asthma
☐☐☐☐ Bronchitis
☐☐☐☐ COPD
☐☐☐☐ Emphysema
☐☐☐☐ Pleurisy
☐☐☐☐ Sinus issues
☐☐☐☐ Other:_____
☐ All normal

Musculoskeletal

C F O P (bone / muscle)
☐☐☐☐ Arm/hand pain/stiff
☐☐☐☐ Arm / hand tingling
☐☐☐☐ Joints grinding
☐☐☐☐ Joints popping
☐☐☐☐ Joint surgery
☐☐☐☐ leg pain / stiffness
☐☐☐☐ leg / foot tingling
☐☐☐☐ low back pain
☐☐☐☐ Mid-back pain
☐☐☐☐ Metal implants
☐☐☐☐ Neck pain / stiffness
☐☐☐☐ Osteoarthritis
☐☐☐☐ Osteoporosis
☐☐☐☐ Rheumatoid arthritis
☐☐☐☐ Scoliosis
☐☐☐☐ Severe stiffness
☐☐☐☐ Shoulder pain
☐☐☐☐ Spinal fracture
☐☐☐☐ Other:_____
☐ All normal

☐☐☐☐ Irregular cycles
☐☐☐☐ Menopausal signs
☐☐☐☐ Other: _____
☐ All normal

Allergies: _____

_____

Comments or other important issues:_____

_____

_____

_____

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Medications:

Medication:	How long:	Reason for taking:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If additional space is needed for your medications, please provide us with a complete list on another form.

Life Style and Social History:

Work schedule: _____

Hobbies/Recreational activities:_____

Exercise level: ☐None ☐Light ☐Moderate ☐Intense Most common routine:_____

Diet: ☐Healthy ☐Normal ☐Poor Alcohol consumption:☐None ☐Slight ☐Moderate ☐Heavy Avg. amt. / week:_____

Coffee, tea, caffeine drinks: ☐None ☐Slight ☐Moderate ☐Heavy Type: _____ Avg. amt. / week:_____

Tobacco use: ☐None ☐Slight ☐Moderate ☐Heavy Type: _____ Avg. amt. / week:_____

Regular anti-inflammatory use (Advil/Aleve/Aspirin/Motrin/Ibuprofen/Naproxen/Naprosyn/Tylenol) How often? _____ ☐None

Family Health History:

Do you have a family history of any of the following? Please indicate all that apply. (F = Father, M = Mother, B = Brother, S = Sister, C = Child)

F M B S C	F M B S C	F M B S C	F M B S C
☐☐☐☐☐ Arthritis	☐☐☐☐☐ Cardiac disease ↑ 40	☐☐☐☐☐ Joint problems	☐☐☐☐☐ Osteoporosis
☐☐☐☐☐ Back/Neck problems	☐☐☐☐☐ Degenerative disc disease	☐☐☐☐☐ Mental/emotional issues	☐☐☐☐☐ Seizures
☐☐☐☐☐ Cancer/Tumors	☐☐☐☐☐ Diabetes	☐☐☐☐☐ Multiple sclerosis	☐☐☐☐☐ Stroke/TIA's
☐☐☐☐☐ Cardiac disease ↓ 40	☐☐☐☐☐ High blood pressure	☐☐☐☐☐ Neurological disease	☐☐☐☐☐ None, All normal

Is there anything else in your current or past medical history that you feel is important for us to know in order for us to identify the main cause of your current symptoms and to rule out anything that would be of concern in administering chiropractic care?

_____

_____

I have read the above information; I understand and certify the answers to be true and correct to the best of my knowledge.
Patient or Guardian Signature _____ Date_____

Informed Consent and Authorization to Treat:

I hereby request and consent to the use of spinal manipulations and other chiropractic procedures as Dr. Fox determines is best for my condition at the time of service (or on the patient named above, for whom I am legally responsible), including various forms of physical therapy and diagnostic X-rays. I consent to have ether Jerry W. Fox, D.C. or another licensed doctor of Chiropractic in the state of Kansas who now or in the future works at this clinic to perform these services.

I have had an opportunity to discuss with Dr. Fox and with other office or clinic personnel the nature and purpose of chiropractic procedures and other procedures used to treat my condition. I understand that the results of these procedures are not guaranteed. I recognize that my body's ability to respond to chiropractic care and my compliance to a treatment plan is essential.

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 care which the doctor feels at the time, based upon the facts then known to him, 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 above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition (or for whom I am legally responsible) and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date _____ Witness Signature _____ Date_____

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Financial Policy:

Our goal is to provide affordable chiropractic care to as many people as possible. In order to do this we expect to receive full payment for our services within a reasonable period of time. We accept a variety of payment options including cash, credit cards, debit cards as well as most insurance plans to help you pay for the services we provide at this clinic.

Patients with insurance plans that cover the services provided at this clinic are expected to pay for their co-pays and deductibles at the time of service. We will do all we can to obtain your benefit information prior to the start of your treatment program. This information will serve only as an estimate of your expected benefit. If your insurance does not pay the full amount expected then you will be responsible for paying the balance remaining on that bill. This balance will become due once the insurance remittance form has been received by our office. Full payment of that bill is expected to be paid within 30 days from the date of service. Balances over 30 days will be handled the same as a cash patient. This policy also applies in cases when the insurance company pays a claim in error and the money is refunded to the insurance company, leaving your account with a balance due.

For all cash patients, full payment is due at the time of service. If full payment is not possible at the time of service, we may allow you to make full payment within 30 days of the date of service. A statement will be mailed out for those balances that are not paid. Balances not paid within 30 days of the first statement will be subjected to a $5.00 service charge for each additional statement mailed out. Balances that are over 90 days old without making a reasonable payment or communication from the patient will be subject to being turned over to a collection agency for payment. I give Fox Chiropractic approval to use, and if necessary share, my personal information in an attempt to collect outstanding balances over 90 days. Service fees from the collection agency may be added to your account balance as allowable in the state of Kansas.

I have read and understand the above financial policy and agree to be held responsible for all procedures and expenses as stated in this financial policy.

Person responsible for payment _____ Signature: _____
If different from patient, what is your relationship to the patient:_____ Phone #_____
Address, if different from patient:_____

Insurance Information: ☐ None, Self Pay

Primary: Insured's name: _____ Date of Birth: _____ Relationship:_____
Insurance company: _____ Policy # _____
Secondary: Insured's name: _____ Date of Birth: _____ Relationship:_____
Insurance company: _____ Policy # _____

Insurance assignment and release: I the undersigned give permission for Jerry W. Fox, dba Fox Chiropractic Clinic, to bill my insurance company directly for payment of the services I receive at this facility and to supply them with the documentation necessary for payment. I authorize the use of my signature on all of my insurance claim submissions made by Fox Chiropractic Clinic.

Name of insured: (Please print as on policy or card) _____

Insured's signature: _____

Pregnancy Release:

I the undersigned, certify that to the best of my knowledge I am not pregnant and give Dr. Fox and his assistants permission to perform an e-ray examination on me. I have been advised that x-rays can be hazardous to an unborn child. The date of my last menstrual period was _____ _____ _____
Patient's Signature Date

Consent to Treat a Minor:

I certify that I am legal guardian for _____. I authorize Jerry W Fox, DC and whomever he may designate as his assistants to administer chiropractic care as he so deems necessary to the above patient who is my **circle** (son) (daughter) (other). If other, state your relationship: _____

Signature of guardian:_____ Date: _____