Potens Wellness Clinic

Today's Date: _____
PIN: _____
D.O.B.: _____

Introduction Patient Case History

PATIENT INFORMATION

Patient Name *(first and last)*: _____
Preferred Name: _____ **Pronouns:** _____
Email Address: _____
Mobile Phone: _____ **Home Phone:** _____
Street Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Date of Birth: _____ **Gender:** _____
How did you hear about us? _____

EMERGENCY CONTACT

Full Name: _____
Emergency Contact Phone: _____ **Emergency Contact Relationship:** _____
Family Doctor: _____ **Family Doctor Phone:** _____
Name of Referring Professional: _____

FINANCIAL INFORMATION

☐ Self-Pay (cash) ☐ Personal Injury/Auto ☐ Other (please specify):
☐ Insurance ☐ Worker's Comp. _____

Primary Insurance
Insurance Name: _____
Relation to Insured:
Self / Spouse / Parent / Child / Other:_____
Other than Self:
Insured's Name: _____
Gender: M / F
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____ **Date of Birth:** _____

Secondary Insurance
Insurance Name: _____
Relation to Insured:
Self / Spouse / Parent / Child / Other:_____
Other than Self:
Insured's Name: _____
Gender: M / F
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____ **Date of Birth:** _____

Responsible Party
Who is responsible for payment? Self / Other - *(relationship)* _____
Other than Self:
Name: (*First, MI, Last)* _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

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Patient Case History

HISTORY OF CURRENT CONDITION

Describe PRIMARY Complaint: _____

Describe WHEN and HOW this began: _____

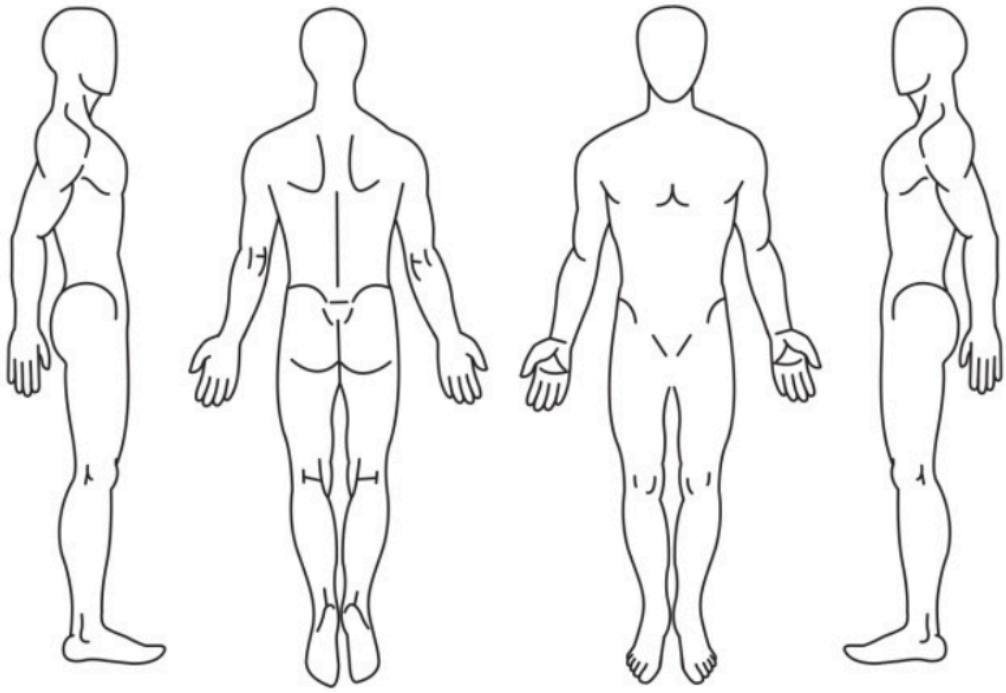
_____

Grade Intensity/Severity of Complaint (0 = no pain, 10 = worst pain possible):

- ☐ 0/10 (no pain)
- ☐ 1-2/10 (mild)
- ☐ 3-4/10 (mild-mod)
- ☐ 5-6 (mod)
- ☐ 7-8/10 (mod-severe)
- ☐ 9-10/10 (severe)

Does the pain/symptom(s) travel to other areas?

- ☐ Yes (*please draw below)*
- ☐ No



Quality of complain/pain:

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy
- ☐ Dull
- ☐ Tingling
- ☐ Numbness
- ☐ Stiff / Tight
- ☐ Other: _____

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Frequency of complaint:

- ☐ Occasional (0-25% of the day)
- ☐ Frequent (51-75%)
- ☐ Intermittent (26-50%)
- ☐ Constant (76-100%)

When is your pain/symptom(s) the worst?

- ☐ Morning
- ☐ Evening
- ☐ All times
- ☐ Afternoon
- ☐ Night

Does anything make your complaint BETTER?

- ☐ Ice
- ☐ Movement
- ☐ Nothing
- ☐ Heat
- ☐ Stretching
- ☐ Other:_____
- ☐ Rest
- ☐ OTC

Does anything make your complaint WORSE?

- ☐ Ice
- ☐ Lying down
- ☐ Coughing or Sneezing
- ☐ Heat
- ☐ Sitting
- ☐ Nothing
- ☐ Movement
- ☐ Standing
- ☐ Other: _____
- ☐ Stretching
- ☐ Sleeping

Which daily activities are affected by this condition? Please check all that apply.

- ☐ Bending over
- ☐ Caring for family
- ☐ Concentrating
- ☐ Cooking
- ☐ Driving
- ☐ Eating
- ☐ Exercising
- ☐ Getting in/out of car
- ☐ Lying down
- ☐ Lifting objects
- ☐ Looking over shoulder(s)
- ☐ Participating in athletic/recreational activities
- ☐ Participating in sexual relations
- ☐ Performing household chores
- ☐ Performing personal care
- ☐ Raising arm(s)
- ☐ Raising out of chair
- ☐ Running
- ☐ Sitting
- ☐ Sleeping (falling or staying asleep)
- ☐ Walking
- ☐ Work duties
- ☐ None
- ☐ Everything
- ☐ Other: _____

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How long can you perform your normal activities before symptoms begin or increase in severity?

- ☐ Symptoms begin or worsen immediately
- ☐ 15 minutes
- ☐ 15-30 minutes
- ☐ 30-60 minutes
- ☐ 1-2 hours
- ☐ 4+ hours
- ☐ Symptoms are not affected by activity

Have you received any other treatment for this complaint?

- ☐ None
- ☐ Chiropractic
- ☐ Medical care
- ☐ Physical therapy
- ☐ Massage
- ☐ Emergency care
- ☐ Other: _____

Have you had any diagnostic testing performed for this complaint?

- ☐ None
- ☐ X-rays
- ☐ MRI
- ☐ CT
- ☐ Other: _____

HISTORY OF SECONDARY CONDITION(S)

Please describe any other complaints that you'd like to address below:

_____

_____

_____

_____

Additional Information for your provider:

_____

_____

_____

_____

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Patient Health History

Allergies:

- ☐ Seasonal
- ☐ Adhesive
- ☐ Metals
- ☐ Medication
- ☐ Fragrances/Essential Oils
- ☐ Other: _____
- ☐ Latex
- ☐ None

Current Medication / Supplement Use:

- ☐ Prescribed medication
- ☐ Opioids
- ☐ Other: _____
- ☐ OTC
- ☐ Multi-Vitamin
- ☐ None
- ☐ NSAIDs
- ☐ Fiber Supplement

Number of Falls in the last 24 months: _____

Past Car Accidents ***(include date and injuries inflicted)*****:**

_____

_____

_____

Past Injuries / Surgeries ***(include date and type of surgery):***

_____

_____

_____

List any major traumas / hospitalizations:

_____

_____

_____

_____

List any major and relevant health problems of first degree relatives ***(i.e. parents, siblings, children)*****:**

_____

_____

_____

Hobbies / Recreation:

_____

Work / Occupation:

_____

Exercise Frequency:

- ☐ None
- ☐ 3-4x / wk
- ☐ 1-2x / wk
- ☐ 5+ / wk

Diet:

- ☐ Balanced
- ☐ Controlled
- ☐ Other: _____
- ☐ Restricted
- ☐ Out-of-control

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Review of Systems

Please check ALL symptoms that you have recently experienced or are currently experiencing.

General / Constitutional:

- ☐ Recent weight loss (without intention)
- ☐ Recent, significant weight gain (without intention)
- ☐ Fever
- ☐ Fatigue
- ☐ None in this category

Musculoskeletal:

- ☐ Neck pain
- ☐ Upper back pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Arm pain/problems
- ☐ Leg pain/problems
- ☐ Painful joints
- ☐ Stiff/swollen joints
- ☐ Sore/Weak muscles
- ☐ Broken bones
- ☐ Other: _____
- ☐ None in this category

Neurological:

- ☐ Tingling (pins & needles)
- ☐ Numbness
- ☐ Dizziness or light headed
- ☐ Frequent or recurrent headaches
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Other: _____
- ☐ None in this category

Mind / Stress:

- ☐ Nervousness / Anxiety
- ☐ Depression
- ☐ Sleep problems
- ☐ Memory loss or Confusion
- ☐ Other: _____
- ☐ None in this category

Genitourinary:

- ☐ Sexual difficulty
- ☐ Kidney stones
- ☐ Burning/Painful urination
- ☐ Change in force/strain with urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Incontinence or bed wetting
- ☐ Other: _____
- ☐ None in this category

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Gastrointestinal:

- ☐ Loss of appetite
- ☐ Blood in stool
- ☐ Change in bowel movement
- ☐ Painful bowel movement
- ☐ Bowel incontinence
- ☐ Frequent diarrhea
- ☐ Constipation
- ☐ Nausea or Vomiting
- ☐ Abdominal pain
- ☐ Other: _____
- ☐ None in this category

Cardiovascular and Heart:

- ☐ Chest pain
- ☐ Rapid or heartbeat changes
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Swelling in hands, ankles, or feet
- ☐ Heart problems
- ☐ Other: _____
- ☐ None in this category

Respiratory:

- ☐ Difficulty breathing
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Asthma or wheezing
- ☐ Lung problems
- ☐ Other: _____
- ☐ None in this category

Eye and Vision:

- ☐ Wearing contacts/glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other: _____
- ☐ None in this category

Ears, Nose, and Throat:

- ☐ Bleeding gums/mouth sores
- ☐ Bad breath or bad taste
- ☐ Dental problems
- ☐ Swollen throat or voice changes
- ☐ Swollen glands in neck
- ☐ Ringing in ears
- ☐ Ear ache or drainage
- ☐ Sinus/Allergy problems
- ☐ Nose bleeds
- ☐ Hearing loss
- ☐ Other: _____
- ☐ None in this category

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Endocrine, Hematologic, and Lymphatic:

- ☐ Thyroid problems
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Gestational diabetes
- ☐ Excessive thirst or urination
- ☐ Cold extremities
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Change in hat or glove size
- ☐ Dry skin
- ☐ Glandular or hormone problem
- ☐ Swollen glands
- ☐ Anemia
- ☐ Easily bruise or bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other: _____
- ☐ None in this category

Skin and Breast:

- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change of appearance of a mole
- ☐ Breast pain
- ☐ Breast lump
- ☐ Breast discharge
- ☐ Other: _____
- ☐ None in this category

Select any that apply to your medical history:

- ☐ Aneurysm
- ☐ Ankylosing Spondylitis
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Cauda Equina Syndrome
- ☐ Connective tissue disease
- ☐ Gout
- ☐ Osteoporosis / Osteopenia
- ☐ Psoriatic arthritis
- ☐ Recent fracture (within 2 months)
- ☐ Recent car accident (within 6 months)
- ☐ Rheumatoid arthritis
- ☐ Spinal surgery
- ☐ Stroke / TIA
- ☐ Vertebral Artery Insufficiency/Stenosis
- ☐ None
- ☐ Uncertain

Women's Health:

Are you pregnant?

- ☐ Yes; Due date: ____/_____/____
- ☐ No

Date of Last Menstrual Period: ____/_____/____

Pregnancies *(date & outcome):*

_____

_____

_____

Cont. on next page >>>

Potens Wellness Clinic

Today's Date: _____
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Women's Health cont.:

Do you experience any of the following symptoms?

- ☐ Irregular periods (unpredictable)
- ☐ Painful periods
- ☐ Abnormal vaginal discharge
- ☐ Endometriosis
- ☐ Infertility
- ☐ Other: _____
- ☐ None

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature: _____ **Date: _____**

Treating Doctor Signature: _____ **Date: _____**

Potens Wellness Clinic, LLC
2800 NE Kendallwood Pkwy Ste 3,
Gladstone, Missouri 64119

Notices of Privacy Practices

HIPAA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and updated laws on 9/23/2013, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: *Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. *Obtain payment from third-party payers. *Conduct normal healthcare operations such as quality assessments and physician certifications. I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used to disclose to carry out treatment, payment, or health care operations. I also understand you are not required to agree with my requested restriction, but if you do agree then you are bound to abide by such restrictions. I further authorize disclosure of all or any part of my patients record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinics charge including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds or the patient's employe. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this account.

This process of determining suitability for Chiropractic Services involves answering fully and truthfully all questions presented to you either written or spoken regarding your past and present health status. If warranted, a physical examination will be performed that can include but is not limited to vitals measurement, systems evaluation, orthopedic tests, and maneuvers (tests that move and stress parts of the body), neurological tests (tests using sharp or dull instruments, smells, or sounds, gently tapping) as well as physical touching. These tests and maneuvers will help the Chiropractor determine what may be causing your complaints. Occasionally some temporary soreness and/or stiffness may occur due to the examination, less frequently aggravation of presenting symptoms or initiation of new symptoms. By signing below, you have authorized the performance of a consultation and examination.

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever they may designate as their assistance to administer treatment, physical examination, orthopedic and neurological evaluation, visual inspection, palpation, X-ray studies, laboratory procedures, chiropractic care, or any clinical services that they deem necessary in my case. The undersigned also consents to observation of therapeutic or diagnostic procedures by staff personnel or medical personnel in training as permitted by the attending practitioner and allowed by clinic policy. Treatment procedures that may be used in your treatment include, but are not limited to, manipulative therapy, activator, joint mobilization, myofascial release, trigger-point therapy, intersegmental traction, electrical therapy, muscle stretching, therapeutic exercises, nutritional and exercise guidance, and any directional handouts. Cases will be managed with all due concern and with the evaluation of response to previous care provided. Home care instructions will be given as appropriate to enhance your treatment program. Compliance with the recommendations for home care and follow-up care is necessary for the resolution of your complaint. Home care instructions will be given as appropriate to enhance your treatment program. Compliance with the recommendations for home care and follow-up care is necessary for the resolution of your complaint. Because of modern techniques and equipment, examination and therapeutic procedures involve a very low risk of complication. Even though serious problems rarely occur with these procedures, risks must be recognized and considered. Any procedure that is intended to help may also do harm. While examination and therapeutic procedures used in this clinic are considered remarkably safe and effective, understand that occasionally there may be adverse reactions that occur. Although the chances of experiencing any of these complications are extremely small, it is the practice of this office to fully inform and educate our patients. These complications include but are not limited to pain, swelling, bruising, discoloration, inflammation, disc injury, sensory changes, bleeding, fracture, fainting, irregular heartbeat, heart attack, spinal cord damage, nausea, burns, soft tissue injury ,stroke dizziness, or weakness. A patient, in coming to Potens Wellness Clinic, LLC, gives our treating doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if they are aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities, which would otherwise not come to the attention of the treating doctor. The doctor provides a specialized, non-duplicating health care service. Our doctor is licensed in special practice and is available to work with other types of providers in your health care regimen. I understand that I am accepted as a patient by a physician at Potens Wellness Clinic, LLC, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request. No guarantee or warranty for a specific cure or result is implied by the acceptance of your case. All patients respond differently to the treatment procedures. Each case must be evaluated separately. If you do not fully understand the above or have questions about anything mentioned in this document, please do not sign it until these matters have been resolved with further discussion. I have read the above explanation of treatment and diagnostic procedures used in this clinic and have myself decided that it is in my best interest to submit to these procedures.

Appointment Reminders and Health Care Information Authorization

At times, our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with these reminders/information and understand that I may be contacted by: phone at home or work, mobile phone, e-mail, text, or postcard. Messages may be left: on answering machine/voicemail at home, work, a mobile phone and/or upon request, these reports are available to be printed or emailed to me for review.

Clinical Summary Report (CCR) regarding EFR

Un understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Potens Wellness Clinic, LLC to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed or emailed to me for review.

Assignment of Benefits

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Potens Wellness Clinic, LLC will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Potens Wellness Clinic, LLC 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.

Print Patient Name:_____ Authorized Signature:_____

Relationship to patient (if not self) _____ Date:_____