True Health PA
11879 West 112th Street #100
Overland Park, KS 66210
Phone (913) 338-1112
info@truehealthkc.com

Patient Demographics

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

Address_____ **City**_____ **State**_____ **Zip Code**_____

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

E-mail Address_____

**Whom may we thank for referring you to True Health?*_____

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: _____

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

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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.

If you cannot be at the office at your scheduled appointment time, please give 24 hours notice. **If 24 hour notice is not given for a missed appointment, an office visit fee of $40 will be charged to your credit card on file.**

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

_____ _____

Signature of patient or legal guardian Date

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Primary Care Physician Name: _____ Telephone number: _____

May we contact your PCP for update on your progress? Yes or No

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

Chief complaint:_____

1. On a scale of 1 to 10 with 10 being the worst pain and 0 being no pain, please rate your current pain level:

   1 2 3 4 5 6 7 8 9 10

2. Have you had a previous injury or accident contributing to your current condition?

   Injury/accident_____ Date of occurrence_____

3. How long has the current condition been present_____

4. Describe the pain (Circle all that apply): **Dull Achy Stiff Tight Sharp Numb Tingling Burning Throbbing** _____

5. Does the pain radiate**: Yes** or **No** Where: _____

6. What makes the pain worse: **Movement Sitting Standing Laying Down** _____

7. What makes the pain better: **Rest Ice Anti-inflammatories Stretching Movement** _____

8. Previous treatment tried: **Chiropractor Physical Therapy Injections OTC medication Rx pain meds**

   _____

9. Progression of Symptoms**: Better Worse Stayed the Same**

Secondary complaint:_____

1. On a scale of 1 to 10 with 10 being the worst pain and 0 being no pain, please rate your current pain level:
   1 2 3 4 5 6 7 8 9 10
2. Have you had a previous injury or accident contributing to your current condition?

   Injury/accident_____ Date of occurrence_____

3. How long has the current condition been present_____
4. Describe the pain: **Dull Achy Stiff Tight Sharp Numb Tingling Burning Throbbing**
5. Does the pain radiate**: Yes** or **No** Where: _____
6. What makes the pain worse: **Movement Sitting Standing Laying Down** _____
7. What makes the pain better: **Rest Ice Anti-inflammatories Stretching Movement** _____
8. Previous treatment tried: **Chiropractor Physical Therapy Injections OTC medication Rx pain meds**
9. Progression of Symptoms**: Better Worse Stayed the Same**

Functional Rating Index

In order to properly assess your condition, we must understand how much your problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4

No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain

2. Sleeping

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4

No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain

3. Personal Care (washing, dressing, etc.)

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4

No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain

4. Traveling (driving, etc.)

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4

No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain

5. Work

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4

No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain

6. Recreation

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4

No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain

7. Frequency of Pain

0 ------- 25% ------- 50% -------75% -----100%

8. Lifting

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4

No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain

9. Walking

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4

No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain

10. Standing

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4

No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain

_____

Patient's Name

_____

Patient's Signature

_____

Date

FOR OFFICE USE ONLY:

Total Score _____/ 40

Secondary Complaints- Please mark **C** for **Current** or **P** for **Past**

Neurological Symptoms:
____ Migraines
____ Headaches
____ Slurred Speech
____ Ringing in Ears

Eyes/Ear/Nose/Throat
____ Change in Vision
____ Sore Throat
____ Gingivitis
____ Nose Bleeds
____ Hearing Loss
____ Seasonal Allergies
____ Altered taste/smell
____ Frequent Cold/Flu

Cardiovascular Symptoms:
____ Chest Pain
____ Palpitation/Racing heart beat
____ Swelling in hands/feet
____ Anemia

Respiratory Symptoms:
____ Recurrent Respiratory Infections
____ Asthma
____ Chest Congestion
____ Wheezing

GI Symptoms:
____ Stomach Pains or Cramping
____ Constipation
____ Diarrhea
____ Reflux or Heartburn
____ Reflux or Heartburn
____ Bloating/Gas
____ Nausea or Vomiting

Skin:
____ Eczema
____ Dermatitis
____ Excessive Sweating
____ Rashes
____ Brittle Nails
____ Hair Loss
____ Easy Bruising
____ Increased Bleeding
____ Numbness/Tingling

Musculoskeletal Symptoms:
____ Joint Pain if yes please specify by circling:
Knee Hip Shoulder Elbow
____ Arthritis
____ Chronic Pain
____ Muscle Aches

Emotional Symptoms:
____ Depression
____ Anxiety
____ Mood Swings
____ Irritability
____ Memory Loss
____ Confusion

Energy Symptoms:
____ Fatigue
____ Hyperactivity
____ Restlessness
____ Insomnia
____ Decreased Libido
____ Stress

Weight Symptoms:
____ Decreased Appetite
____ Weight Gain
____ Inability to Lose Weight
____ Food Cravings
____ Binge Eating
____ Water Retention

Please list any symptoms not mentioned above:
_____
_____
Have you ever had any type of food sensitivity test done: **Yes** or **No**

Medical History

____Hypertension	____Heart Disease	____Migraines	____Liver Disease	____Rheumatoid Arthritis
____Diabetes	____Pinched Nerve	____Cancer	____Kidney Disease	____Fibromyalgia
____High cholesterol	____Herniated disc	____Ulcers	____Osteoporosis	____Thyroid problems
____Pacemaker	____Stroke	____Arthritis	____Bleeding Disorders	_____TMJ w/ prior tx

Surgical History- Please list procedure and date

_____

_____

_____

Medications/Allergies

Current Prescription and Non-Prescription Medications: **Please list past and present use of NSAIDs, Tylenol, Steroid Injections, and narcotics, <u>with</u> start and stop dates:**

_____

_____

_____

Allergies:

Injection History

Have you previously had a joint injection? Yes No

If yes, please list the date or dates of injection:_____

Please list the name of medication injected:_____

Where was the injection done?_____

Did it give you relief? Yes No

Social History

Intake of following: Cigarettes_____ packs/day Alcohol_____drinks/week Caffeine_____cups/day
Exercise frequency: ___Never ___Daily ___Weekly ___Walks ___Runs ___Swims
___Other_____

Occupation: _____ Does work mostly involve: ___Sitting ___Standing ___Light labor
___Heavy labor

Are your Hobbies, Recreation Activities and Exercise Regimen Impacted by your present problem? Explain

_____

_____

_____

Family History

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

If yes, whom?_____

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents, siblings)
_____Heart Disease _____Diabetes _____Cancer _____Arthritis _____Other

Patient Goals

What activities would you like to participate in if this pain/problem did not exist:_____
_____

Short term goals- to be accomplished in 3 months or less:
_____
_____

Long term goals- to be accomplished in 6 months:
_____
_____