

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance card(s). All information you supply is confidential. We comply with all Federal privacy standards. Please print clearly.

Patient Name: _____ Date: _____

Liberty Park Chiropractic

Jason Hutchison, D.C.
Stephen Gumpenberger, D.C.
1512 NE 96th Street, Ste A
Liberty, MO 64068
P: 816-407-7200

What are the top 3 complaints you are being seen for today:

1)	2)	3)
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Describe the onset of symptoms and date of onset if known for each condition:

1) Date:	2) Date:	3) Date:
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Have you experienced these symptoms before:

1) <input type="checkbox"/> Never <input type="checkbox"/> On and off <input type="checkbox"/> For Years	2) <input type="checkbox"/> Never <input type="checkbox"/> On and off <input type="checkbox"/> For Years	3) <input type="checkbox"/> Never <input type="checkbox"/> On and off <input type="checkbox"/> For Years
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How do you feel your symptoms are changing with time:

1) <input type="checkbox"/> Improving <input type="checkbox"/> Worsening <input type="checkbox"/> No change	2) <input type="checkbox"/> Improving <input type="checkbox"/> Worsening <input type="checkbox"/> No change	3) <input type="checkbox"/> Improving <input type="checkbox"/> Worsening <input type="checkbox"/> No change
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What are the qualities of these symptoms:

1) <input type="checkbox"/> Achy <input type="checkbox"/> Burning <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stiff <input type="checkbox"/> Throbbing <input type="checkbox"/> Tight <input type="checkbox"/> Sore <input type="checkbox"/> Other: _____	2) <input type="checkbox"/> Achy <input type="checkbox"/> Burning <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stiff <input type="checkbox"/> Throbbing <input type="checkbox"/> Tight <input type="checkbox"/> Sore <input type="checkbox"/> Other: _____	3) <input type="checkbox"/> Achy <input type="checkbox"/> Burning <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stiff <input type="checkbox"/> Throbbing <input type="checkbox"/> Tight <input type="checkbox"/> Sore <input type="checkbox"/> Other: _____
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On a scale of 1-10 (0=no pain, 10=most severe pain) how would you rate the intensity of your pain today:

1) 1-10: _____	2) 1-10: _____	3) 1-10: _____
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How often do you experience your symptoms:

1) <input type="checkbox"/> Occasionally <input type="checkbox"/> Intermittent <input type="checkbox"/> Frequently <input type="checkbox"/> Constant	2) <input type="checkbox"/> Occasionally <input type="checkbox"/> Intermittent <input type="checkbox"/> Frequently <input type="checkbox"/> Constant	3) <input type="checkbox"/> Occasionally <input type="checkbox"/> Intermittent <input type="checkbox"/> Frequently <input type="checkbox"/> Constant
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What time of the day do your symptoms feel better:

1) <input type="checkbox"/> AM <input type="checkbox"/> Mid-Day <input type="checkbox"/> PM <input type="checkbox"/> None	2) <input type="checkbox"/> AM <input type="checkbox"/> Mid-Day <input type="checkbox"/> PM <input type="checkbox"/> None	3) <input type="checkbox"/> AM <input type="checkbox"/> Mid-Day <input type="checkbox"/> PM <input type="checkbox"/> None
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What aggravates your symptoms:

1)	2)	3)
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What alleviates your symptoms:

1)	2)	3)
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Have you seen another provider for this condition (If so please provide their name and when):

1) _____ _____	2) _____ _____	3) _____ _____
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Dr.'s Initials: _____

Please answer the next 3 sections only if they apply to the condition(s) you are seeking treatment for:

Lower Back Pain

Does the pain radiate into your leg(s)? Yes No

If yes, please describe: _____

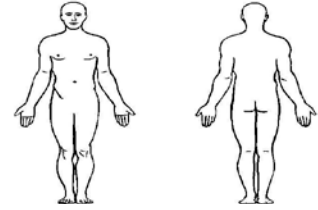
Does the pain radiate into your abdomen? Yes No

Do you have any impairment of the bowel or urinary function? Yes No

Do you have numbness or tingling into the leg(s)? Yes No

If yes, please describe: _____

Please mark on the bodies where you're having pain/symptoms:



Neck/Upper Back Pain

If you have a neck injury, does it affect: (check all that apply) Hearing Vision Balance Cause ringing in ears

Do you hear grating sounds? Yes No Do you feel pressure or pain behind your eyes? Yes No

Does the pain radiate into your arm(s) Yes No Where: _____

Do you have difficulty turning your head? Yes No If so in which direction? Right Left Up Down

Headaches

Do you get headache's? Yes No If yes how often? _____ per day/week/month

Location of headache's : _____ Does medication help your headaches: Yes No

Do you experience the following with your headache's: Pain or cracking in the jaw- Yes No

Abnormal blood pressure-Yes No Nausea, vomiting or visual disturbances-Yes No

When was your last eye exam by a doctor? _____ Results of exam: _____

If you are female are you pregnant? Yes No Not sure Date of last menstrual period: _____

Please list current medications/vitamins/supplements and the frequency and dosage if known. None currently

1) _____ Start Date: _____ Frequency: _____ Dosage: _____

2) _____ Start Date: _____ Frequency: _____ Dosage: _____

3) _____ Start Date: _____ Frequency: _____ Dosage: _____

4) _____ Start Date: _____ Frequency: _____ Dosage: _____

5) _____ Start Date: _____ Frequency: _____ Dosage: _____

List any known allergies you have had to any medications: No known allergies

Medication: _____ Symptoms Associated: _____

Medication: _____ Symptoms Associated: _____

Medication: _____ Symptoms Associated: _____

Have you ever had any surgeries or hospitalizations? Yes No If yes, please list:

Type of surgery/hospitalization: _____ Date: _____ Type of surgery/hospitalization: _____ Date: _____

_____ Date: _____ _____ Date: _____

_____ Date: _____ _____ Date: _____

Have you been x-rayed, had an MRI or CT Scan in the last 12-18 months? Yes No When/Where _____

Have you seen a Chiropractor before? Yes No Who/When _____

Do you have a primary care physician? Yes No Who _____

Have you ever had a Motor Vehicle Injury Sports Injury Work Injury Slip/Fall Injury If yes please explain:

Patient Name: _____

Doctor's Initials: _____

Has any doctor diagnosed you with Hypertension presently? Yes No If yes, who and when: _____

Has any doctor diagnosed you with Diabetes presently? Yes No If yes, what kind: Type 1 Type 2

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c >9.0%? Yes No

Please check all additional complaints you have currently or had in the past:

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	Back problems
<input type="checkbox"/>	<input type="checkbox"/>	Hip disorders	<input type="checkbox"/>	<input type="checkbox"/>	Knee injuries	<input type="checkbox"/>	<input type="checkbox"/>	Foot/ankle pain	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder problems	<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Wrist pain
<input type="checkbox"/>	<input type="checkbox"/>	TMJ issues	<input type="checkbox"/>	<input type="checkbox"/>	Poor posture	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Pins & Needles	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Bruising	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Food sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Ear ringing	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Chronic ear infections
<input type="checkbox"/>	<input type="checkbox"/>	Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>	Loss of taste	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid issues	<input type="checkbox"/>	<input type="checkbox"/>	Immune disorders
<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	Low energy	<input type="checkbox"/>	<input type="checkbox"/>	Frequent infection	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	Prostate issues	<input type="checkbox"/>	<input type="checkbox"/>	Erectile dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	PMS symptoms
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Low libido	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Sudden weight gain	<input type="checkbox"/>	<input type="checkbox"/>	Sudden weight loss

Do you have any diseases or medical problems not listed? Yes No If yes, please list: _____

Family History (Some issues are hereditary, please tell us about the health of your immediate family members):

Relative:	Age(if living):	State of Health:	Illnesses:	Age at death:	Cause of Death:
Mother		<input type="checkbox"/> Good <input type="checkbox"/> Poor			<input type="checkbox"/> Natural <input type="checkbox"/> Illness
Father		<input type="checkbox"/> Good <input type="checkbox"/> Poor			<input type="checkbox"/> Natural <input type="checkbox"/> Illness
Sister 1		<input type="checkbox"/> Good <input type="checkbox"/> Poor			<input type="checkbox"/> Natural <input type="checkbox"/> Illness
Sister 2		<input type="checkbox"/> Good <input type="checkbox"/> Poor			<input type="checkbox"/> Natural <input type="checkbox"/> Illness
Brother 1		<input type="checkbox"/> Good <input type="checkbox"/> Poor			<input type="checkbox"/> Natural <input type="checkbox"/> Illness
Brother 2		<input type="checkbox"/> Good <input type="checkbox"/> Poor			<input type="checkbox"/> Natural <input type="checkbox"/> Illness
Other		<input type="checkbox"/> Good <input type="checkbox"/> Poor			<input type="checkbox"/> Natural <input type="checkbox"/> Illness

Social History (Please tell us about your health habits):

Select all of the following that apply to complete this statement:

I Smoke _____ Never Current Daily Smoker Current sometimes Smoker Former Smoker Decline to answer

If a current smoker what is your level of interest in quitting smoking? Not interested Somewhat interested Very interested

Alcohol Consumption: None Casual Drinker Moderate Drinker Heavy Drinker Decline to answer

Caffeine Consumption: None <3 drinks day 3-6 drinks day >6 drinks day Decline to answer

Drug Use: None Recreational Addiction Decline to answer

Exercise: Never Daily Weekly Decline to answer

Is there any additional information you would like the doctor to know about before beginning care? _____

Clinician ONLY Notes:	
HT: _____	
WT: _____	
BP: _____ P: _____ :	<input type="checkbox"/> Follow up recommended with PCP <input type="checkbox"/> No Follow up needed <input type="checkbox"/> Already under PCP care
Patient Name: _____ Doctor's Initials: _____	

Personal Information

Today's Date: _____ Whom may we thank for referring you? _____

Patient's Name: _____
(First name) (M.I.) (Last name) (suffix) (Nickname)

Birth Date: _____ Age: _____ Sex: M F SS#: _____

Marital Status: Single Married Divorced Legally separated Widowed Partnered Spouse Name: _____

Race: White Black Asian American Indian Native Hawaiian/Pacific Island Other _____

Ethnicity: Hispanic or Latin Not Hispanic or Latin Multi-Racial: Yes No Unknown

Preferred Language: English Spanish Other _____

Contact Information

Home Mailing Address: _____ City: _____ State: _____ Zip: _____

Email Addresses: (H): _____ (W): _____

Phone #'s: (H): _____ (C): _____ (W): _____

Preferred method of contact: Home Email Work Email Home Address Home Phone Cell Phone Work Phone

Emergency Contact: _____ Relationship: _____ P: _____

Occupational Information

Employment Status: Full-time Part-time Student Homemaker Unemployed Retired

Occupation: _____ Employer: _____

Job Requirements: Sit Stand Bend Lift Carry Travel Other: _____

Insurance Information

Is this condition due to an accident? Yes No Date of Accident: _____ Type: Auto Work Home Other

Primary Insurance Company: _____ Policy Holder Name: _____ DOB: _____

Who is financially responsible for this account: Self Parent Other: _____

By signing below I am stating 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.

Patient or Guardian Signature: _____ Date: _____

Liberty Park Chiropractic

1512 NE 96th St, Ste A

Liberty, MO 64068

Jason Hutchison, D.C.

Stephen Gumpenberger, D.C.

Authorization & Assignment

I authorize **Liberty Park Chiropractic** to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information & is available by request for review. You have a legal right to review our Notices of Privacy Practices before you sign this consent, and we encourage you to read it in full. I, the undersigned do hereby appoint Liberty Park Chiropractic authority necessary to endorse and cash my checks, drafts or money orders which are payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by this clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered 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 me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Patient or guardian signature: _____ **Date:** _____

Informed Consent

I hereby authorize the physician and staff at **Liberty Park Chiropractic** to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions. I certify that the information provided in this paperwork is correct to the best of my knowledge. I will not hold my doctor or any staff member of **Liberty Park Chiropractic** responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risks Possibilities Associated with Chiropractic Care: Soreness- Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort. Soft Tissue Injury- Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or soft-tissue injury. Rib Injury- Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk. Stroke-Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments. If you have any questions concerning the above statements, please ask your doctor.

(Please check one below, if you have questions our doctor's will be happy to answer them before administering any treatment)

Before consenting to care, I have questions regarding the risks associated with chiropractic treatment.

____ Initial and sign below if questions fully answered.

Having carefully read the above, I have no questions and give my informed consent to have chiropractic treatment administered.

Patient or guardian signature: _____ **Date:** _____

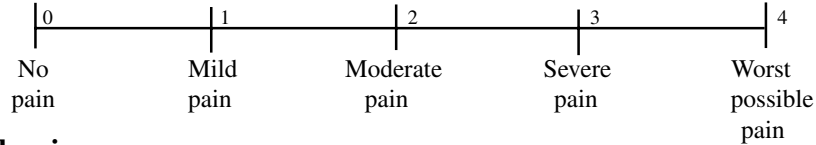
Functional Rating Index

For use with **Neck and/or Back Problems** only.

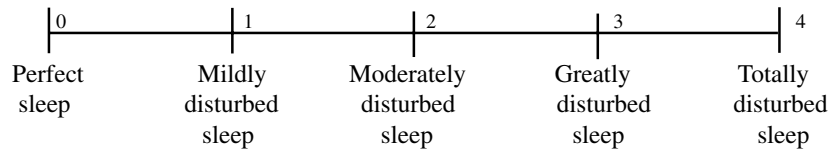
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.

For each item below, please circle the number which most closely describes your condition right now.

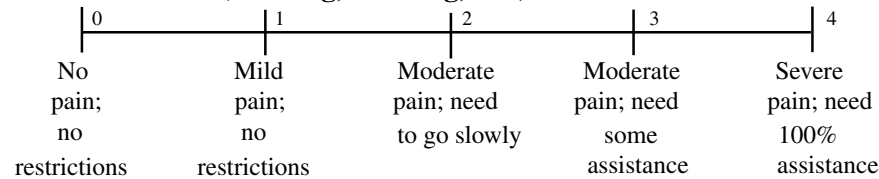
1. Pain Intensity



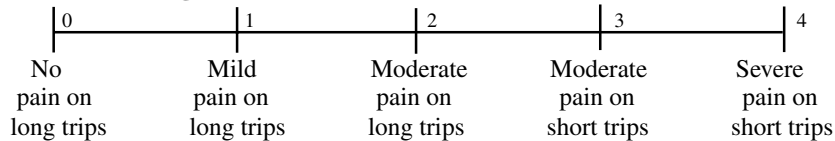
2. Sleeping



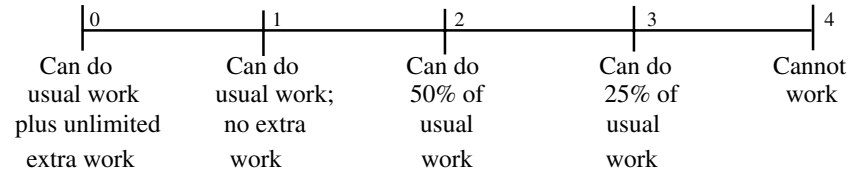
3. Personal Care (washing, dressing, etc.)



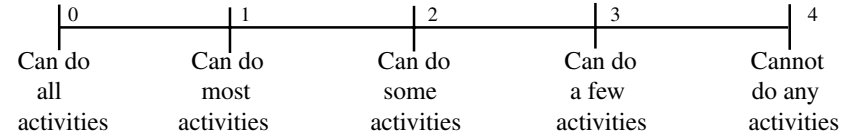
4. Travel (driving, etc.)



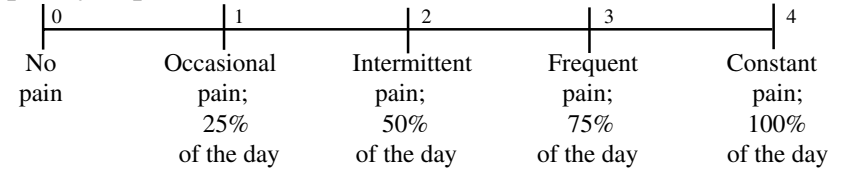
5. Work



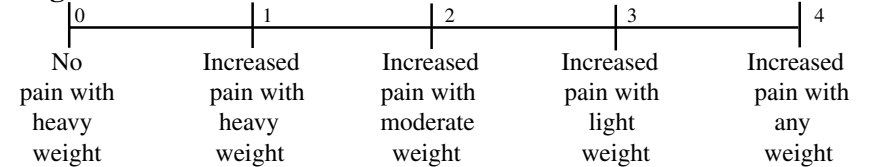
6. Recreation



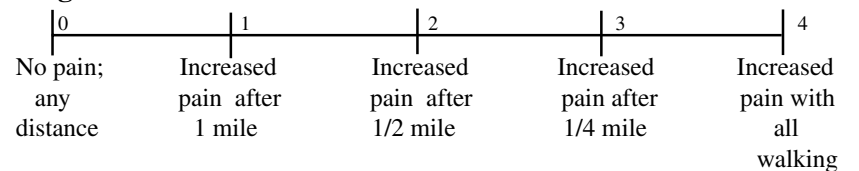
7. Frequency of pain



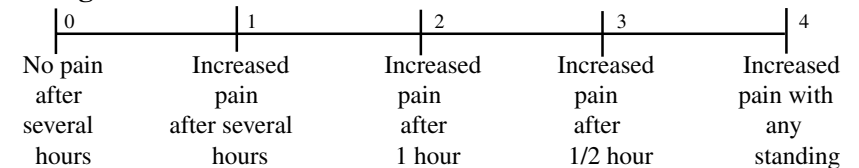
8. Lifting



9. Walking



10. Standing



Name _____

PRINTED

Signature _____

Total Score _____

Updated Date/Score: _____ / _____

Updated Date/Score: _____ / _____

Date _____