Complete Joint And Spine Therapy 3223 North Webb Rd, Suite 2 Wichita, KS 67226 316-609-3040

Patient Information

Name ______________________________ Soc Sec. # ______________

Last Name *First Name* *Initial*

Parent/Guardian (if patient is a minor)______________________________

Address ______________________________

City ______________________ State __________ ZIP __________

Home phone: __________ Work Phone:__________ Cell Phone/Pager: __________

May we call you at work regarding appointment changes? ☐ Yes ☐ No

Sex ☐ M ☐ F Age _____ Birthdate __________ ☐Single ☐ Married ☐Widowed ☐Separated ☐Divorced

Referring Physician: ______________Referring Physician Phone: __________

Family Physician: ______________ Family Physician Phone: __________

Patient Employed By ______________________ Occupation __________

Business Address ______________________ Business Phone __________

In case of an emergency, who should be notified? ______________________

Relationship: ______________________ Phone ______________________

Who may we thank for referring you to our practice?______________________

Primary Insurance: ______________________________

Insured ______________________ Insured's DOB: ______________

Employer______________________

Relation to Patient ______________ Insured's Soc. Sec # ______________

Additional Insurance: ______________________________

Insured ______________________ Insured's DOB: ______________

Employer______________________

Relation to Patient ______________ Insured's Soc. Sec # ______________

Assignment and Release

I, the undersigned, certify that I (or my dependents) have insurance coverage as noted above and assign all insurance benefits, otherwise payable to me for services rendered, payable directly to Complete Joint and Spine Therapy (CJST). I understand that I am financially responsible for all charges whether or not they are paid by any insurance plan I participate in. Further, I understand that if I fail to pay for my charges and CJST refers my account to an outside attorney or collection agency, I am also responsible for all collection fees that an outside attorney or collection agency may charge to collect the charges I owe. I hereby authorize CJST to release all information necessary to secure payment for services they provide me (or my dependents). I authorize the use of my signature on all insurance submissions. I authorize CJST to release my (or my dependents) medical records to my referring, primary and treating physicians and diagnostic centers.

____

Responsible Party Signature Relationship, if not the patient Date

May we call you at work regarding appointment changes? (Circle one)
Yes or No

If yes, best daytime phone # to reach you at: ____________________

Accident/Surgery Information:

Type: ☐ None ☐ Work Comp ☐ Auto ☐ Other (Must be specific incident)

Accident/Injury/pain onset Date: ________________________________

Accident/Injury/onset Details: ________________________________

Have you had surgery related to today's visit? ☐ Yes ☐ No

Date of Surgery (if applicable): ____________

Date of your next physicians appointment relating to this diagnosis: ______________

Have you had any of the following medical or Rehabilitative services for this injury/episode?

	Yes	No		Yes	No
Chiropractor	___	___	Ct Scan	___	___
EMG/NCV	___	___	General Practitioner	___	___
Massage Therapy	___	___	MRI	___	___
Myelogram	___	___	Neurologist	___	___
Occupational Therapy	___	___	Orthopedist	___	___
Physical Therapy	___	___	Podiatrist	___	___
Emergency Room Care	___	___	X-Rays	___	___

Other: ____

CONSENT FOR CARE & TREATMENT

I, the undersigned, give my consent for Complete Joint and Spine Therapy to furnish medical care and treatment to ______________________ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian/Responsible Party ____________________ **Date** ____________

Acknowledgment of Receipt of Notice of Privacy Practices

Your protected health information may be used and disclosed to carry out treatment, payment, or health care operations.

By your signature below, you acknowledge that you have received Complete Joint & Spine Therapy's Notice of Privacy Practices for Protected Health Information ("Privacy Notice") which provides a complete description of the uses and disclosures that the Complete Joint & Spine Therapy office/staff may use of your protected health information, as well as your rights in relation to such information.

Complete Joint & Spine Therapy has reserved the right to change its privacy practices described in its Privacy Notice. In accordance with law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

Signature ________________________________

Or

Signature of Personal Representative of Patient _______________________

Description of representative's Authority to Act for patient ______________

Date: ____________________

3223 N Webb Rd Ste 2, Wichita, KS 67226

Ph: 316-609-3040 Fax 316-609-3090

Authorization When Patient Requests Use or Disclosure of Protected Health Information

I hereby authorize Complete Joint and Spine Therapy to disclose the following information:

Any medical treatment, appointment times or billing issues related to my care, as if I were the person calling or inquiring.

to: ______________________________

Name of person or entity Relationship

____

Name of person or entity Relationship

____

Name of person or entity Relationship

This authorization will expire upon my discharge from CJST to my primary care physician. I understand I have a right to revoke the authorization in writing except to the extent Complete Joint and Spine Therapy has taken action or has relied on the authorization. This authorization may be revoked by my requesting revocation in writing and delivering a copy of the same to Complete Joint and Spine Therapy.

The information used or disclosed under the authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy laws.

______________________________ Date:______________

Signature of Patient

Or:

____

Signature of Personal Representative of Patient

______________________________ Date:____________

Description of Representative's Authority to Act for Patient

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COMPLETE JOINT AND SPINE THERAPY 3223 North Webb Rd, Suite 2 Wichita, KS 67226 316-609-3040

Patient Name: ______________________ Today's Date: __________
Age: ____ Date of Birth: ____________ Date of Last Physical Examination: __________
What is the reason for your visit/current problem? ______________________
Is this a work related injury? ☐ No ☐ Yes If yes, date of injury: ______________________

Symptoms
Check(√) Symptoms you currently have or have had in the past ONE year

GENERAL
- ☐ Chills
- ☐ Fever
- ☐ Dizziness
- ☐ Fainting
- ☐ Depression
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms ☐Hips
- ☐ Back ☐Legs
- ☐ Feet ☐Hands
- ☐ Neck ☐Shoulder

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequency of urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive thirst
- ☐ Loss of Bowel control
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE,EAR,NOSE,THROAT
- ☐ Bleeding gums
- ☐ Difficulty swallowing
- ☐ Crossed eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Vision-flashes
- ☐ Vision halos
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Sinus problems
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Loss of hearing
- ☐ Ringing in ears
- ☐ Earache
- ☐ Ear discharge

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Changes in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

Men Only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Pain in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

Women only
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Vaginal discharge
- ☐ Nipple discharge
- ☐ Other

Date of last period? __________

Have you had a mammogram? __________

Are you pregnant? __________

Conditions
Check(√) conditions you currently have or have had in the past ONE year

- ☐ AIDS/HIV
- ☐ Angina
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chronic Fatigue Syndrome
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Kidney stones
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Meningitis
- ☐ Migraine Headache
- ☐ Mitral valve prolapse
- ☐ CHF
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Parkinsons disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Psychiatric Care
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Syphilus
- ☐ Suicide attempts
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Urinary tract infections
- ☐ Venereal Disease

Medications
List any you are currently taking/strengths/dosages

____
____
____
____

Pharmacy ______________ Phone __________

Medication Allergies
medications/substances/reactions

____
____
____
____
____

Health History

more on other side➔

Patient Name: ______________________

Family History Fill In Health Information about Your Family

Relation	Age	State of Health	Age at Death	Cause of death
Father				
Mother				
Brothers				
Sisters				

Check (✓) If your blood relative had any of the following:

	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay fever	
	Cancer	
	Chemical dependency	
	Diabetes	
	Heart disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

Hospitalizations/ Surgeries

Year	Hospital Treating Physician	Reason for Hospitalization/Surgery & Outcome

Health Habits

Check (✓) which substances you use & describe how much you use

	Substance	
	Caffeine	
	Tobacco	
	Recreational Drugs	
	Alcohol	

Occupational

Check (✓) if your work exposes you to the following:

	Stress		**Hazardous Material**
	Heavy Lifting		**Other**

Occupation: ______________________

Are you currently working? YES NO

If released from work:

By Whom? ______________ When: ______________

Why? ______________________

____

Have you ever had a blood transfusion? YES NO

Please give approximate dates: ______________

Serious Illness/Injuries	Date	Outcome

I certify that the above information is correct to the best of my knowledge. I will not hold my physician or any members of their staff responsible for errors or omissions that I may have made in the completion of this form.

Patient Signature ______________________ Date ______________

Review Signature ______________________ Date ______________