

## INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. (PLEASE PRINT.)

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Marital Status: S M W D Number of Children \_\_\_\_\_

Please circle one payment type: Cash Check Master Card/Visa American Express  
Your Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years On Job \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Your Social Security # \_\_\_\_\_

Do you have Medicare? Yes \_\_\_\_\_ No \_\_\_\_\_ Do you have Medicaid? Yes \_\_\_\_\_ No \_\_\_\_\_  
Name of Spouse or Parent \_\_\_\_\_ Their Birthdate \_\_\_\_\_

Spouse Employed By \_\_\_\_\_ Occupation \_\_\_\_\_ Years On Job \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone # \_\_\_\_\_ Spouse's SS# \_\_\_\_\_ Driver's License # \_\_\_\_\_

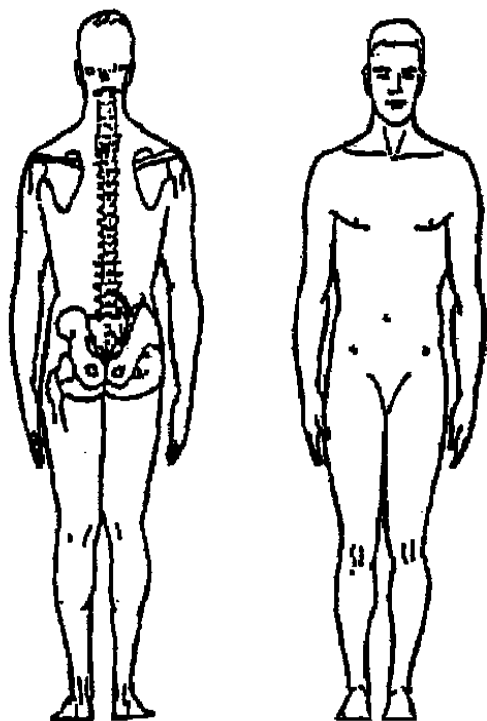
Does your spouse have health insurance at work? Yes \_\_\_\_\_ No \_\_\_\_\_

### COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc.....

### MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)



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Referred to our office by: \_\_\_\_\_

How payment will be made: \_\_\_\_\_ Type of Insurance: \_\_\_\_\_  
\_\_\_\_\_ Cash \_\_\_\_\_ Worker's Comp. \_\_\_\_\_ Health Insurance  
\_\_\_\_\_ Check \_\_\_\_\_ Credit Card \_\_\_\_\_ Automobile Insurance Policy

Is your condition due to an accident? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of accident?  
\_\_\_\_\_

Type of accident? Auto \_\_\_\_\_ Work/On Job \_\_\_\_\_ At Home \_\_\_\_\_ Other  
\_\_\_\_\_

Have you ever been in an auto accident? Past Year \_\_\_\_\_ Past 5 Years \_\_\_\_\_ Over 5 Years \_\_\_\_\_  
Never \_\_\_\_\_

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature \_\_\_\_\_ Date

Or Guardian Signature \_\_\_\_\_ Date  
\_\_\_\_\_

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.

# Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name \_\_\_\_\_ Date \_\_\_\_\_

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

**O – OCCASIONAL**  
**F – FREQUENT**  
**C – CONSTANT**

**O F C**

**GENERAL**

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness/depression
- Neuralgia
- Numbness
- Sweats
- Tremors

**MUSCLE & JOINT**

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Lumbago
- Neck pain or stiffness
- Pain between shoulders
- Pain or numbness in:
- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet
- Painful tail bone
- Poor posture
- Sciatica
- Spinal Curvature
- Swollen joints

**O F C**

**GASTRO-INTESTINAL**

- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Distension of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

**EYES, EARS, NOSE & THROAT**

- Asthma
- Colds
- Crossed eyes
- Deafness
- Dental Decay
- Earache
- Ear discharge
- Ear noises
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Failing vision
- Far sightedness
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness
- Nosebleeds
- Sinus infection
- Sore throat
- Tonsillitis

**O F C**

**CARDIO-VASCULAR**

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

**RESPIRATORY**

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

**SKIN**

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose veins

**GENITO-URINARY**

- Bed-wetting
- Blood in urine
- Frequent urination
- Inability to control kidneys
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Pus in urine

**FOR WOMEN ONLY**

- Congested breasts
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge
- Yes  No Are you pregnant?

**CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:**

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Cold sores     | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Scarlet fever    |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Gout          | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Diphtheria     | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eczema         | <input type="checkbox"/> Influenza     | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Typhoid fever    |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Lumbago       | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Malaria       | <input type="checkbox"/> Polio              | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chorea           | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Measles       | <input type="checkbox"/> Rheumatic fever    | <input type="checkbox"/> Whooping cough   |

**PLEASE PRINT**

What's your major complaint? \_\_\_\_\_

List surgical operation and years: \_\_\_\_\_

Drugs you now take:  Nerve pills  Pain killers  Muscle relaxers  
 "Pep" pills  Tranquilizers  Birth control pills

Others: \_\_\_\_\_

Age of mattress: \_\_\_\_\_  Comfortable  Uncomfortable  Do you use a bed board? \_\_\_\_\_

Are you wearing:  Heal lifts  Sole lifts  Inner soles  Arch supports

Have you been in an auto accident:  Past year  Past five years  Over five years  Never

Describe: \_\_\_\_\_

Have you ever had any mental or emotional disorders?  Yes  No When? \_\_\_\_\_

Have others in your family had such disorders?  Yes  No When? \_\_\_\_\_

**HAVE YOU EVER:**

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| Been knocked unconscious?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Used a cane, crutch, or other support?             | <input type="checkbox"/> | <input type="checkbox"/> |
| Been treated for a spine or nerve disorder?        | <input type="checkbox"/> | <input type="checkbox"/> |
| Had a fractured bone?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Been hospitalized for anything other than surgery? | <input type="checkbox"/> | <input type="checkbox"/> |

**DESCRIBE BRIEFLY**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DO YOU:**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| Now take vitamins or minerals?           | <input type="checkbox"/> | <input type="checkbox"/> |
| Think you may need vitamins or minerals? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have an allergy to any drug?             | <input type="checkbox"/> | <input type="checkbox"/> |

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DATE OF LAST:**

- |                      | Less than 6 months       | 6-18 months              | Over 18 months           | Never                    |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Spinal examination   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Physical examination | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood test           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest X- ray         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Spinal X-ray         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental X-ray         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Urine test           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**HABITS**

- |          | Heavy                    | Moderate                 | Light                    | None                     |
|----------|--------------------------|--------------------------|--------------------------|--------------------------|
| Alcohol  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Coffee   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tobacco  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Drugs    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Appetite | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

NAME \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

SCHMITZ CHIROPRACTIC, LLC  
**KYLE G. SCHMITZ, D.C., ART**  
1502 Prehistoric Hill Dr.  
Imperial, MO 63052  
Phone: 636-464-8828  
Fax: 636-464-8838

CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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 the procedure which the doctor feels at the time, based upon the facts then known to him or her, 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 and for any future condition(s) for which I seek treatment.

Date: \_\_\_\_\_

\_\_\_\_\_ Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Relationship or authority if not signed by patient

**KYLE G. SCHMITZ, D.C., ART  
1502 Prehistoric Hill Drive  
Imperial, MO 63052**

**THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

In the course of your care as a patient at the office of Dr. Kyle G. Schmitz, D.C., ART we may use or disclose personal and health related information about you in the following ways:

- \*Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- \*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- \*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- \*If we are providing health care services to you based on the orders of another health care provider.
- \*If we provide health care services to you in an emergency.
- \*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- \*If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.
- \*If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Kyle G. Schmitz, 1502 Prehistoric Hill Drive, Imperial, MO 63052. If you would like further information about our privacy policies and practices please contact: Dr. Kyle G. Schmitz at 636-464-8828.





***SIGNATURE ON FILE FOR HEALTH BENEFITS:***

**PATIENT OR AUTHORIZED PERSON'S SIGNATURE:** I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed: \_\_\_\_\_

**INSURED OR AUTHORIZED PERSON'S SIGNATURE:** I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Signed: \_\_\_\_\_