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.)

____
____
____
____
____
____
____

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.

Auto Injury Information

Name ____ Today's Date ________________________
Date of Accident __________________________________ Time of Accident _____________________________________ AM PM
Location of Accident ____
Type of Accident: [ ] Auto/Traffic [ ] Work/On Job [ ] At Home [ ] Other ____
Describe how the accident happened in your own words: ____
____
____
____

Name of Hospital: _______________________________________ Attended by Dr. ____
Were you x-rayed at the hospital? [ ] Yes [ ] No If so, what was the diagnosis? ___________________________________
Were you admitted to the hospital? [ ] Yes [ ] No How long did you stay? ______________________________________
What treatment was rendered? ____
What recommendations were made? ____
List any other doctors you have seen as a result of this accident: ____
____
Have you lost any time from work because of this accident? [ ] Yes [ ] No If yes, give days of disability: ________________________
Totally disabled from ______________ to ____________ Partially disabled from ____________ to _____________
Have you returned to work since the accident? [ ] Yes [ ] No Were you wearing a seat belt? [ ] Yes [ ] No
What kind of vehicle hit yours? ______________________________ What kind of vehicle were you in? _________________________
If auto accident, were you the [ ] Driver [ ] Passenger [ ] Pedestrian?
If passenger, were you sitting in the [ ] Front [ ] Right Rear [ ] Left Rear? [ ] Other ?_____________________________
Did your vehicle hit other vehicle(s)? [ ] Yes [ ] No Estimated speed of your vehicle at impact? __________ MPH
Was your vehicle hit by another vehicle(s)? [ ] Yes [ ] No Estimated speed of other vehicle at impact? __________ MPH
Did your car strike the other(s) involved? [ ] Yes [ ] No or did the other car strike yours? [ ] Yes [ ] No [ ] Undetermined

VEHICLE YOU WERE IN:	OTHER VEHICLE
Driver ______________________	Driver: ______________________
Insured: ______________________	Insured: ______________________
Address: ______________________	Address: ______________________
Phone: ______________________	Phone: ______________________
Auto Insurance Co.: ______________	Auto Insurance Co.: ______________
Ins. Co. Address: ______________	Ins. Co. Address: ______________
Adjuster: ______________________	Adjuster: ______________________
Phone: ______________________	Phone: ______________________
Policy #: ______________________	Policy #: ______________________
Claim # ______________________	Claim # ______________________

Did you require post-accident hospitalization? [ ] Yes [ ] No

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

[ ] Headache	[ ] Irritability	[ ] Numbness in toes	[ ] Face flushed	[ ] Feet cold
[ ] Neck pain	[ ] Chest pain	[ ] Shortness of breath	[ ] Buzzing in ears	[ ] Hands cold
[ ] Neck stiff	[ ] Dizziness	[ ] Fatigue	[ ] Loss of balance	[ ] Stomach upset
[ ] Sleeping problems	[ ] Head seems too heavy	[ ] Depression	[ ] Fainting spells	[ ] Constipation
[ ] Back pain	[ ] Pins & needles in Arms	[ ] Light bothers eyes	[ ] Loss of smell	[ ] Cold sweats
[ ] Nervousness	[ ] Pins & needles in Legs	[ ] Loss of memory	[ ] Loss of taste	[ ] Fever
[ ] Tension	[ ] Numbness in fingers	[ ] Ears ring	[ ] Diarrhea	[ ] ________________

Symptoms other than above:
____
Have you lost days of work? [ ] YES [ ] NO Dates:
____
Name of your Insurance Company involved:
____
Name of person at your Insurance Company responsible for injuries:
____
Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? [ ] YES [ ] NO
Do you have an attorney who has advised you in this case? [ ] YES [ ] NO Name:
____
Address of Attorney: ____ Phone No:
____
Patient’s Signature: ____ Date:
____

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:

☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Miscarriage	☐ Scarlet fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Appendicitis	☐ Diphtheria	☐ Heart disease	☐ Mumps	☐ Tuberculosis
☐ Arteriosclerosis	☐ Eczema	☐ Influenza	☐ Pleurisy	☐ Typhoid fever
☐ Arthritis	☐ Emphysema	☐ Lumbago	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Polio	☐ Venereal disease
☐ Chorea	☐ Fever blisters	☐ Measles	☐ Rheumatic fever	☐ 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	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	____________
Used a cane, crutch, or other support?	☐	☐	____________
Been treated for a spine or nerve disorder?	☐	☐	____________
Had a fractured bone?	☐	☐	____________
Been hospitalized for anything other than surgery?	☐	☐	____________

DO YOU:			
Now take vitamins or minerals?	☐	☐	____________
Think you may need vitamins or minerals?	☐	☐	____________
Have an allergy to any drug?	☐	☐	____________

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X- ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

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 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.

This notice is effective as of ____________________. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

________________________   __________________________   __________

Name (Printed please)   Signature   Date

If you are a minor, or if you are being represented by another party

_____________________   ________________________________   _______

Personal Representative Printed   Personal Representative Signature   Date

____

Description of the authority to act on behalf of the patient.

PAGE 2

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:____