PEAKHEALTH

Comprehensive Health History Forms

7555 W. 150th Street, Overland Park, KS 66223
Phone: (913) 685-0950 Fax: (913) 685-2941

Patient Name _____ DOB_____ Age _____ Sex: M or F

Address _____ City _____ State_____ ZIP _____

Home Phone_____ Mobile Phone _____

Email _____ Preferred way to reach you: ❍ Phone ❍ Text ❍ Email

SS#_____ Status: ❍ Single ❍ Married ❍ Widowed ❍ Divorced ❍ Separated ❍ Minor

Race: ❍ Native American ❍ Asian ❍ African American ❍ Caucasian ❍ Hawaiian ❍ Decline

Ethnicity: ❍ Hispanic or Latino ❍ Not Hispanic or Latino ❍ Decline Preferred Language_____

Occupation _____ Employer _____ Work Phone _____

In case of emergency: Name_____ Relationship _____ Phone_____

How did you hear about us? _____

What specific condition prompted you to choose us for your healthcare needs? _____

INSURANCE INFORMATION

Who is responsible for this account? ❍ Self ❍ Other _____

Name on account / relationship _____

Insurance Company _____

Policy # _____ Group # _____

Is patient covered by additional insurance? ❍ Yes ❍ No If yes, name/relationship _____

Insurance Company _____

Policy # _____ Group # _____

ACCIDENT INFORMATION

Is your condition due to an accident? ❍ Yes ❍ No Date _____

Type of accident? ❍ Auto ❍ Work ❍ Home ❍ Other _____

To whom have you reported the accident? ❍ Auto Insurance ❍ Employer ❍ Work Comp ❍ Other _____

Attorney name, if applicable _____

Assignment and Release I understand and agree that (regardless of whatever health or medical benefits I have), I am ultimately responsible to pay PEAK HEALTH, LLC, the balance due on my account for any professional services rendered and for any supplies, tests or medications provided.

I hereby authorize payment of any health insurance or medical plan benefits directly to PEAK HEALTH, LLC, for medical services rendered and for any supplies, tests or medications provided.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to PEAK HEALTH, LLC, all rights to payments and benefits and all legal and other health plan that I (or my child, spouse, or minor dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). This assignment includes, but not limited to, a designation that PEAK HEALTH, LLC, can act on my/our behalf, as our representative or ERISA representative, as to any initial claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to PEAK HEALTH, LLC, as a result of services rendered by PEAK HEALTH, LLC, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. This assignment and designation remains in effect unless revoked in writing, and a photocopy is to be considered as valid and enforceable as the original.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative *Signature of Patient, Parent, Guardian or Personal Representative*

_____ _____ _____

Relationship to Patient *Date* *Patient Initials* *Date*

By initialing, I am agreeing that I have completed this page to the best of my knowledge

PREVIOUS CARE

What treatment have you received for this condition? _____

Did this treatment resolve the condition? ❍ Yes ❍ No Explain_____

Primary Care physician's name _____

Clinic name_____ Phone _____

Current Medications

Name of Medication or Supplement	Dosage/How Long	For what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have your medications/supplements ever caused side effects or problems? ❍ Yes ❍ No Explain _____

_____

_____

Have you had prolonged or regular use of:

NSAIDS (Advil, Aleve, etc.), Motrin or Aspirin ❍ Yes ❍ No

Tylenol ❍ Yes ❍ No

Acid Blockers (Tagament, Zantac, Prilocec) ❍ Yes ❍ No

Frequent Anti-biotic (>3x a year) ❍ Yes ❍ No

Do you have any surgical devices in your body?

(pins, screws, plates, etc) ❍ Yes ❍ No

If yes, explain _____

_____

Lifestyle History

Choose your exercise level: ❍ Inactive ❍ Light Activity ❍ Moderate Activity ❍ Heavy Activity ❍ Vigorous Activity

Please check all that apply:

❍ Tobacco: Type_____ Amount/day _____ Regularly exposed to second hand smoke? ❍ Yes ❍ No

❍ Alcohol: How many drinks per week _____ ❍ Coffee/Caffeine Drinks: How many cups/day? _____

Do you currently or previously use recreational drugs? ❍ Yes ❍ No If yes, what types/method (IV, inhale, smoke) _____

_____

Work Activity Level: ❍ Full-Time ❍ Part-Time ❍ Homemaker ❍ Student ❍ Unemployed

Hours per week_____ Time spent mostly ❍ Sitting ❍ Walking ❍ Standing

Current Condition

If you could erase 3 health issues, what would they be? _____

_____

What do you hope to achieve in today's visit? _____

When did the condition(s) begin? _____

Is the condition getting worse? ❍ Yes ❍ No ❍ Unknown Rate the severity of your pain 1-10 (10 being severe)_____

The condition is related to: ❍ Auto ❍ Job ❍ Lifting ❍ Home Injury ❍ Slip/fall ❍ Slept wrong ❍ Other _____

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Patient Initials *Date*

Medical History Please check all that apply

Surgeries: Please indicate the year and include comments/results

____ None Reported _____
____ Appendectomy _____
____ Cardiac Bypass _____
____ C-Section _____
____ Cosmetic _____
____ Gall Bladder _____
____ Implants _____
____ Lasik _____
____ Tonsillectomy _____
____ Other _____
____ Bunionectomy _____
____ Cataracts _____
____ Carpal Tunnel _____
____ Ear Tubes _____
____ Hysterectomy _____
____ Knee _____
____ Spinal Fusion _____
____ Wisdom Discectomy _____

Injuries: Please indicate the year and include comments/results

____ Back Injury _____
____ Head Injury _____
____ Neck Injury _____
____ Soft Tissue _____
____ Broken Bone/Fracture _____
____ Industrial _____
____ Severe Fall _____
____ Other _____

Health History Please check all that apply (past or present). CIRCLE CURRENT conditions

___ ADD
___ AIDS/HIV
___ Alcoholism
___ Allergies
___ Alzheimer's
___ Anemia
___ Appendicitis
___ Arthritis
___ Asthma
___ Atopic Dermatitis
___ Bed Wetting
___ Bleeding Disorders
___ Blood Clot
___ Bronchitis
___ Cancer
___ Cataracts
___ Cerebral Palsy
___ Chemical Dependency
___ Chest Pain
___ Chicken Pox
___ Cholera
___ Chronic Fatigue Syndrome
___ Crohn's/Colitis
___ CRPS (RSD)
___ Constipation
___ CVA (Stroke)
___ Cystic Kidney Disease
___ Depression
___ Diabetes
___ Ear Infections
___ Eating Disorder
___ Eczema
___ Emphysema
___ Epilepsy/Convulsions
___ Fetal Drug Exposure
___ Fibromyalgia
___ Fractures
___ Gallbladder Disorder
___ German Measles
___ Glaucoma
___ Goiter
___ Gonorrhea
___ Gout
___ Headaches
___ Heart Attack
___ Heart Disease
___ Hepatitis
___ Hernia
___ Herniated Disk
___ Herpes/Lesions/Shingles
___ High Blood Pressure
___ High Cholesterol
___ Hormone Replacement
___ Hypoglycemic
___ Influenza Pneumonia
___ IBS (Irritable Bowel Syndrome)
___ Jaundice
___ Kidney Stones
___ Liver Disease
___ Lung Disease
___ Lupus Erythema
___ Malaria
___ Measles
___ Migraine Headaches
___ Miscarriage
___ Mononucleosis
___ Multiple Sclerosis
___ Mumps
___ Nervous Breakdown
___ Osteoporosis
___ Pacemaker
___ Parkinson's Disease
___ Pinched Nerve
___ Pleurisy
___ Pneumonia
___ Polio
___ Pregnancy
___ Prostate Problems
___ Psoriasis
___ Psychiatric Care
___ Rheumatoid Arthritis
___ Rheumatic Fever
___ Scarlet Fever
___ Scoliosis
___ Seizure Disorder
___ Sickle Cell Anemia
___ Sinusitis
___ Sleep Apnea
___ Spina Bifida
___ STD
___ Stroke
___ Suicide Attempt(s)
___ Swelling Feet
___ Thyroid Problems
___ Tonsillitis
___ Tuberculosis
___ Tumors, Growths
___ Typhoid Fever
___ Ulcers
___ Unspec. Pleural Effusion
___ Vaginal Infections
___ Vertigo
___ Whooping Cough
___ Other:_____

Daily Activities Effects of current condition on daily performance.

1 = No effect 2 = Slightly Limited 3 = Limited 4 = Mostly Limited 5 = Unable to Perform

Bending	1 2 3 4 5	Driving	1 2 3 4 5	Reading	1 2 3 4 5	Sleeping	1 2 3 4 5
Carrying	1 2 3 4 5	Gardening	1 2 3 4 5	Roll Over	1 2 3 4 5	Standing	1 2 3 4 5
Climbing	1 2 3 4 5	Jumping	1 2 3 4 5	Sexual Activity	1 2 3 4 5	Walking	1 2 3 4 5
Dancing	1 2 3 4 5	Lifting	1 2 3 4 5	Shoveling	1 2 3 4 5	Working	1 2 3 4 5
Chores	1 2 3 4 5	Sports	1 2 3 4 5	Sit/Desk Work	1 2 3 4 5		
Dressing	1 2 3 4 5	Pushing	1 2 3 4 5	Sit to Stand	1 2 3 4 5		

By initialing, I am agreeing that I have completed this page to the best of my knowledge _____ _____

Patient Initials *Date*

Review of Symptoms Indicate which of the following you've experienced in the *last 1-2 months*

1 = Never 2 = Rarely 3 = Occasionally 4 = Frequently 5 = Constantly

General Systems

Hearing:

Decreased Hearing	1 2 3 4 5
Ear Pain/Ear Infection	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Nose Bleeds	1 2 3 4 5
Nose Drainage/Runny	1 2 3 4 5
Ringing in Ears	1 2 3 4 5
Stuffy Nose	1 2 3 4 5

Eyes:

Blurred/Double Vision	1 2 3 4 5
Cataracts	1 2 3 4 5
Eye Pain	1 2 3 4 5
Glaucoma	1 2 3 4 5
Itching	1 2 3 4 5
Photophobia	1 2 3 4 5
Tearing	1 2 3 4 5
Wear Glasses/Contacts	1 2 3 4 5

Skin:

Eczema	1 2 3 4 5
Dryness	1 2 3 4 5
Hives	1 2 3 4 5
Itching	1 2 3 4 5
Lumps	1 2 3 4 5
Rashes	1 2 3 4 5

Cardiovascular

Chest Pain	1 2 3 4 5
Claudication (leg pain/ache)	1 2 3 4 5
Blood Clotting	1 2 3 4 5
Difficulty Breathing when lying	1 2 3 4 5
Heart Murmur	1 2 3 4 5
Heart Problems	1 2 3 4 5
High Blood Press	1 2 3 4 5
Low Blood Pressure	1 2 3 4 5
Pacemaker/Defibrillator	1 2 3 4 5
Palpitations	1 2 3 4 5
Shortness of Breath w/Exertion/Exercise	1 2 3 4 5
Swelling of Legs	1 2 3 4 5
Varicose Veins	1 2 3 4 5

Throat/Respiratory

Asthma/ Wheezing	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Dentures	1 2 3 4 5
Difficulty Swallowing	1 2 3 4 5
Shortness of Breath	1 2 3 4 5

MusculoSkeletal

Ankle/Foot Pain	1 2 3 4 5
Arthritis	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Hip Pain	1 2 3 4 5
Joint Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Muscle Cramping	1 2 3 4 5
Muscle Stiffness(in a.m.)	1 2 3 4 5
Neck Pain	1 2 3 4 5
Pain Between Shoulder	1 2 3 4 5
Pain Wakens You	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Weakness in Arms/Legs	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5

Endocrine

Change in Appetite	1 2 3 4 5
Diabetes	1 2 3 4 5
Fatigue/Drowsiness	1 2 3 4 5
Goiter	1 2 3 4 5
Hair Loss/Hair Growth	1 2 3 4 5
Hypo/Hyper Thyroid	1 2 3 4 5
Poor Sleep/Insomnia	1 2 3 4 5
Weight Loss/Gain	1 2 3 4 5

Neurological

Anxiety/Panic	1 2 3 4 5
Bi-Polar Disorder	1 2 3 4 5
Confusion	1 2 3 4 5
Cry Often	1 2 3 4 5
Daytime Sleepiness	1 2 3 4 5
Depression	1 2 3 4 5
Dizziness /Fainting	1 2 3 4 5
Loss of Consciousness	1 2 3 4 5
Forgetfulness	1 2 3 4 5
Considered Suicide	1 2 3 4 5
Have Hallucinations	1 2 3 4 5
Have Overused Alcohol	1 2 3 4 5
Headaches	1 2 3 4 5
Loss of Memory	1 2 3 4 5
Numbness	1 2 3 4 5
Poor Concentration	1 2 3 4 5
Restless Leg Syndrome	1 2 3 4 5
Seizures	1 2 3 4 5
Sleep Disturbance	1 2 3 4 5
Slurred Speech	1 2 3 4 5
Stroke	1 2 3 4 5
Unsteadiness of Gait	1 2 3 4 5

Gastrointestinal

Abdominal Pain/Cramps	1 2 3 4 5
Abnormal Stool	1 2 3 4 5
Bloating/Gas	1 2 3 4 5
Constipation	1 2 3 4 5
Crohn's Disease	1 2 3 4 5
Diarrhea	1 2 3 4 5
Hemorrhoids	1 2 3 4 5
Rectal Bleeding	1 2 3 4 5
Reflux/Heartburn	1 2 3 4 5
Nausea/Vomiting	1 2 3 4 5

Reproductive

Burning Urination	1 2 3 4 5
Frequent Urination	1 2 3 4 5
Decreased Libido	1 2 3 4 5
STI's / STD's	1 2 3 4 5
Infertility	1 2 3 4 5

Males Only:

Erectile Dysfunction	1 2 3 4 5
Genital Pain	1 2 3 4 5
Hernia	1 2 3 4 5
Impotence	1 2 3 4 5
Prostate Enlargement	1 2 3 4 5

Females Only:

Hot Flashes	1 2 3 4 5
Irregular Menstruation	1 2 3 4 5
Ovarian Cysts	1 2 3 4 5
Pain During Sex	1 2 3 4 5

NOTES:_____

_____

_____

_____

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_____

_____

_____

By initialing, I am agreeing that I have completed this page to the best of my knowledge _____ _____

Patient Initials *Date*

Family History Check all immediate family health history that apply

	Mother	Father	Brother(s)	Sister(s)	Children
ADHD					
ALS or other Motor Neuron Diseases					
Asthma					
Autism					
Auto Immune Disease (ex: Lupus, Hashimotos)					
Breast or Ovarian Cancer					
Bipolar Disease					
Cancers					
Celiac Disease					
Colon Cancer					
Dementia					
Depression					
Diabetes					
Eczema/Psoriasis					
Environmental Sensitivities					
Food Allergies, Sensitivities or Intolerances					
Genetic Disorders					
Heart Disease					
Hypertension					
Inflammatory Bowel Disease					
Inflammatory Arthritis (ex: Rheumatoid Psoriatic)					
Irritable Bowel Syndrome					
Multiple Sclerosis					
Obesity					
Parkinson's					
Psychiatric Disorders					
Stroke					

IMPORTANT: We do NOT work for an insurance company. Rather we work 100% for our patients. Insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However the treatment we recommend and the fees we charge WILL ALWAYS BE BASED ON YOUR INDIVIDUAL NEEDS, NOT YOUR INSURANCE COVERAGE.

By initialing, I am agreeing that I have completed this page to the best of my knowledge _____ _____

Patient Initials *Date*

PEAKHEALTH

Terms of Acceptance
Patient Health Information Consent Form

PATIENT INFORMATION

When a person seeks Chiropractic care and we accept a person for such care it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment: A specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease other than the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to locate, analyze and correct vertebral subluxation by specific adjustments. We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

Authorization for Release of Medical Records I request that payment of authorized Insurance/Medicare/Medicaid benefits be made directly to Peak Health, LLC for any services provided to me by this medical facility. I hereby authorize the release of all medical information about me to the Health Care Finance Administration or other insurer or agency for purposes of determining medical necessity or processing claims at Peak Health, LLC . This authorization is in effect until I choose to revoke it. I have the right as a patient to revoke this authorization in writing at any time.

Signature:_____ Date: _____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the doctors and staff of Peak Health, LLC have my permission to perform x-ray(s). I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period:_____

Signature:_____ Date: _____

Consent to Evaluate and Adjust a Minor Child

I,_____ being the parent or legal guardian of _____

Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care

Signature:_____ Date: _____

PEAKHEALTH

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____

Patient Name or Legal Guardian (print)

_____ _____

Signature Date

Financial Policy

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 coinsurance amounts will be discussed at the time of your visit.

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

_____ _____

Signature Date

OFFICE USE ONLY:

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

_____ _____

Date Attempt

_____

Staff Name