Arnold Chiropractic

Phone: (316) 794-2480

228 N. Main P.O. Box 643 Goddard, KS 67052

WELCOME

The doctor and staff of Arnold Chiropractic welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

INSURANCE

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

Please print

Date _____

Name_____Address_____

City _____ State _____Zip _____ Home Phone _____

Day Phone_____ E-mail Address_____ Social Sec. #_____

Age _____ Date of Birth _____Sex (M) (F) Height _____Weight _____

Occupation _____Employer _____Address _____

Married/Single/Widowed/Divorced Name of Spouse/Guardian_____ Children_____

Referred by_____

What insurance company will this case be covered by? _____
Is any other member of your family being treated in this office? _____
How did you hear about this office?_____
For what problem have you had chiropractic care before?_____
Were the results satisfactory? Yes_____ No_____ N/A_____
Are you currently seeking: Consultation Chiropractic Adjustments Acupuncture Nutritional Guidance?

Current Problem

What condition are you seeking help for? _____
How do you believe your problem (pain) began? _____
When did you first notice this problem/pain?_____

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Current Problem Continued
What positions or activities aggravate your condition?_____
What positions or activities relieve your condition?_____
When have you ever had this condition before or a similar condition?_____
Have you lost any work? _____ if so when did you last work _____
What other doctors have you seen for this ailment?_____
What treatment was recommended? _____Did it help?_____

Health History
Family physician's name and address_____
Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc. (even as a child)?_____
When & where?_____
Are you allergic to anything you are aware of?_____
Have you ever broken any bones? (fractures) _____ Any dislocations? _____
What operations have you had? _____Year _____
_____Year _____
Have you ever had any cosmetic surgery, breast implants, etc.? _____Year _____
Have you had any surgery to replace hip, knee, etc.? _____Year _____
When was your last: Blood tests _____ Urinalysis_____MRI _____ CT Scan _____
Ultrasound_____ Radiation Treatment_____ X-Ray_____
What conditions/diseases have you been diagnosed with?_____
Do you have any health problem the doctor should be aware of? _____
Do you faint easily? _____ Have you lost or gained weight in the past year? _____
What conditions have you been treated for by a physician in the past year? _____
_____
What medications, herbs, vitamins or over the counter products (aspirin included) are you presently taking?
_____

Personal Habits:
How much do you drink of: Water?_____ Coffee/Tea? _____ Alcohol? _____Soda? _____
Do you use: Chewing tobacco/Cigarettes _____ Quantity _____ How many times a week do you eat out? ___
Do you exercise regularly? Yes No What kind of exercise? _____
Hobbies _____

Women Only:
How old were you when you began your period: _____ Age at Menopause: _____
During your cycle or menopause, any history of (circle all that apply): Breast Cysts, Clots, Cramps, Headaches, Heavy Bleeding, Hot Flashes, Irritability, Irregular cycles, Mood Swings, Night Sweats, Ovarian Cysts, PMS, Urinary Incontinence, Yeast Infections, Other:_____
Date of last menstrual period _____ Do you have any reason to believe that you may be pregnant? Yes No
Are you seeking relief for any of the above listed female problems? Yes No

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PRIVACY STATEMENT

I understand that all health information disclosed in this office is kept strictly confidential and will not be released to anyone with out my consent. By signing below, I agree to allow Arnold Chiropractic to provide all needed information to the doctors of this office, the chiropractic radiologist who may be called on for expert consultation on my x-rays, as well as my insurance carrier.

ACCEPTANCE AS PATIENT

By signing below, I understand and agree that the doctor of Arnold Chiropractic has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Nutritional Guidance

By signing below, I understand that the suggested nutritional program is not intended as a treatment for any disease. This adjunctive schedule of nutrients is provided with the intent of supporting the physiological and biochemical processes of the human body, and not to diagnose, treat, cure, or prevent any disease or condition.

Insurance Assignment of Benefits

By signing below, I authorize my insurance carrier(s)/Medicare/Medigap to submit payment directly to Arnold Chiropractic for all claims filed on my behalf by this office.

_____ _____

Date Signature of patient/guardian

Please note: **during adverse weather conditions, the Office will be closed if Goddard schools are closed.

Use this space for any additional information you may wish to discuss: