Swickard Chiropractic Clinic of Shawnee, P.A.
17202 Midland Drive, Shawnee, KS 66217

Mark A. Swickard, DC
Bret Lickteig, DC

Workers Compensation Intake Form

First Name: _____ M.I. _____ Last Name: _____

Address: _____City _____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____

Sex M F Marital Status M S D W Date of Birth_____Age_____Social Security #_____

If married, Spouse's Name:_____# of Children_____

Occupation_____Employer_____

Primary Care Physician Name:_____
Address:_____ Phone _____
I give you permission to share a brief summary of my case and diagnosis with my primary care physician.
□ Yes □ No Initial: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____
Name of most recent Chiropractor: _____

Referred by: _____

1. Reasons for seeking chiropractic care:

Primary reason:
_____

Secondary reason:
_____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):
_____
_____
_____

3. Past Health History:

A. Please indicate if you have a history of any of the following:
□ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
□ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
□ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other _____
□ None of the above

B. Previous Injury or Trauma:
_____

Have you ever broken any bones? Which?
_____

C. Allergies: _____

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D. Surgeries:

Date _____ Type of Surgery _____

_____ _____

_____ _____

_____ _____

E. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery _____ Outcome _____

_____ _____

_____ _____

_____ _____

F. Prior Imaging (ie., X-rays, MRI, CT, etc):

What Images were performed? _____ Reason they were done: _____

_____ _____

_____ _____

_____ _____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer	□ Strokes/TIA's	□ Headaches
□ Cardiac disease	□ Neurological diseases	□ Diabetes
□ Psychiatric disease	□ Adopted/Unknown	□ Cardiac disease below age 40
□ Other _____		□ None of the above

Deaths in immediate family: _____

Cause of parents or siblings death _____ Age at death

_____

_____

_____

_____

Social and Occupational History:

A. Job description:

_____

B. Work schedule:

_____

C. Recreational activities:

_____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

_____

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Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes □ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia □ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use □ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here?
_____
_____
_____
_____

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Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What movements/activities make the symptom worse?
  - Please describe:_____
- What makes the symptom better?
  - Please describe:_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Doctor's Notes:

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What movements/activities make the symptom worse?
  - Please describe:_____
- What makes the symptom better?
  - Please describe:_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Doctor's Notes:

Workers Compensation Intake Form

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What movements/activities make the symptom worse?
  - Please describe:_____
- What makes the symptom better?
  - Please describe:_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Doctor's Notes:

Symptom 4 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What movements/activities make the symptom worse?
  - Please describe:_____
- What makes the symptom better?
  - Please describe:_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Doctor's Notes:

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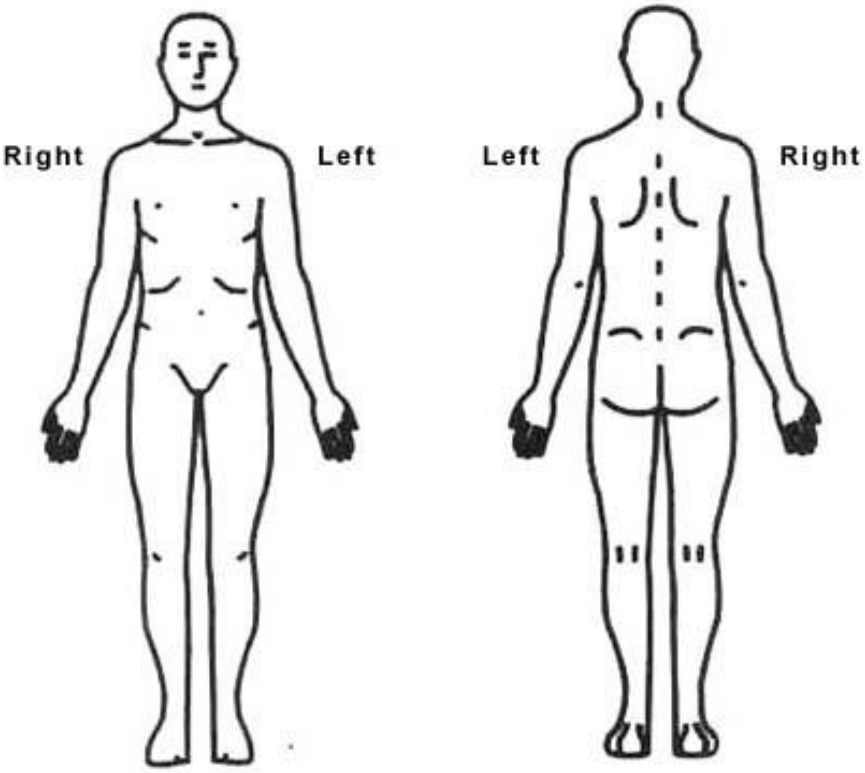
Please indicate sites of **pain** with an "X". (×××)
Does the **pain radiate (travel)**? If so, mark with an "arrow". (→→→)



Do you have headaches?

□ Yes □ No, skip to next page.

If yes, please answer the following:

a. Mark where you get your headache(s) with an "X"

b. **On a scale from 0-10, with 10 being the worst, indicate the intensity of your headache:** 1 2 3 4 5 6 7 8 9 10

c. **What describes your headaches?** (circle all that apply)
Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other: _____

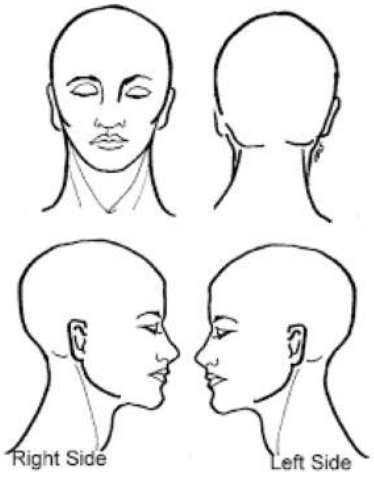
d. How often do they occur?
_____ X/week _____ X/month _____ Sporadic

e. Are your headaches worse at certain times of the day or night?
Morning Afternoon Evening Night Unaffected time of day

f. **When did your headaches begin?** _____

g. **What makes your headaches worse?** _____

h. **What makes your headaches better?** _____



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Accident Mechanism of Injury

Date of Accident: _____ Hour of Accident: _____ AM / PM

Where did the accident occur? _____ What State?_____

Please describe, in detail, how the accident happened: _____

_____

_____

_____

1. Did you hit your head as a result of the injury? **Yes** / **No**
   - **a.** If yes, where? **Front/Back/Left Side/Right Side**
2. Were you unconscious as a result of the injury? **Yes** / **No**
   - a. If yes, how long? _____ (Minutes/Hours)
3. Did you feel pain immediately after the accident? **Yes / No**
   - a. Other symptoms felt immediately following: _____
4. Where did you go following the accident?
   - **a. Employer's office**
   - **b. Hospital**
   - **c. Home**
   - **d. Doctor's Office**
   - **e. Other**
5. If you went to the hospital or doctor, when did you go? _____(Date/Time)
   - a. How did you get there? **Ambulance** / **Police Car** / **Private Transportation**
6. Were you admitted? **Yes** / **No**
   - a. If "YES", how long? _____
7. Name of Hospital? _____ Attended by Dr. _____
8. What treatment was given? (Circle all that apply) **None** / **X-rays** / **Pain Medication** / **Stitches** / **Muscle Relaxants** / **Bandaged** / **Cervical Collar** / **Physical Therapy** / **Instructed Regarding Concussion** / **Instructed Regarding Sprains & Strains** / **Instructed to Call an Orthopedist** / **Instructed to Call a Private Physician** / **Referred to This Office** / **Other**: _____
9. What other doctor have you seen as a result of this injury? _____
10. Do you have difficulty in excessive: **Standing** / **Walking** / **Riding** / **Bending** / **Twisting**
11. Do you have difficulty in excessive lifting: **Light** / **Moderate** / **Heavy** / **Repetitive**
12. Symptoms other than above: _____

Compensation Carrier Information:

Name of Compensation Carrier: _____ Phone: _____

Address of Compensation Carrier: _____

City: _____ State: _____ Zip Code: _____

Claim Number: _____

_____ _____

Patient Signature Date

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HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

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PRIMARY INSURANCE:

INSURANCE COMPANY:_____

INSURED'S NAME: _____RELATIONSHIP TO INSURED:_____

INSURED'S BIRTHDATE:_____ PHONE NUMBER:_____

ADDRESS:_____CITY:_____ STATE:_____ ZIP:_____

EMPLOYER NAME: _____

SECONDARY INSURANCE

INSURANCE COMPANY:_____

INSURED'S NAME: _____RELATIONSHIP TO INSURED:_____

INSURED'S BIRTHDATE:_____ PHONE NUMBER:_____

ADDRESS:_____CITY:_____ STATE:_____ ZIP:_____

EMPLOYER NAME: _____

RELEASE OF INFORMATION:

I _____ give permission to the staff at Swickard Chiropractic Clinic of Shawnee, P.A. to share any information related to my care, account and services to the following people:

NAME: (LAST, FIRST, MI): _____
RELATIONSHIP: _____
ADDRESS_____CITY:_____ STATE:_____ ZIP: _____
PHONE: _____

NAME: (LAST, FIRST, MI): _____
RELATIONSHIP: _____
ADDRESS_____CITY:_____ STATE:_____ ZIP: _____
PHONE: _____

NAME: (LAST, FIRST, MI): _____
RELATIONSHIP: _____
ADDRESS_____CITY:_____ STATE:_____ ZIP: _____
PHONE: _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Swickard Chiropractic Clinic of Shawnee, P.A. for services performed.

Patient or Guardian Signature _____ Date_____

Name/Initial: _____ Date: _____

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Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name: _____ Last Name: _____
Email address: _____@_____
Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail
By providing my e-mail address, I understand that authorized personnel from Swickard Chiropractic may communicate with me regarding scheduling, treatment, receipts, statements, appointment reminders, health education, and promotional information. If you do not consent to e-mail communication, please initial here. _____

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language: _____**

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer
Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*

Medication	Dosage and Frequency (i.e. 5mg once a day, etc.)	Reason for Taking

Do you have any medication allergies?

Medication	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*
Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____