CONFIDENTIAL HEALTH INFORMATION

Baltuska CHIROPRACTIC

Baltuska Chiropractic
Dr. Kelly Baltuska, DC
13830 Santa Fe Trail Drive
Suite 102
Lenexa, KS 66215
Office: 913-283-9803

General Patient Information

Name_____ Date _____

Address_____ City_____ State_____ Zip_____

Primary Phone_____ (Home / Work / Cell) **Employer** _____

Email Address:_____

Date of Birth_____ Age_____ Sex: Male / Female Height_____ Weight_____

Are you covered by any of these 4 major Health Insurance Companies?
If yes, circle one and provide card: Blue Cross Blue Shield / United HealthCare / Cigna / Aetna

Emergency Contact_____ Phone_____ Relation_____

Whom can we thank for referring you to our clinic?_____

Current Complaint

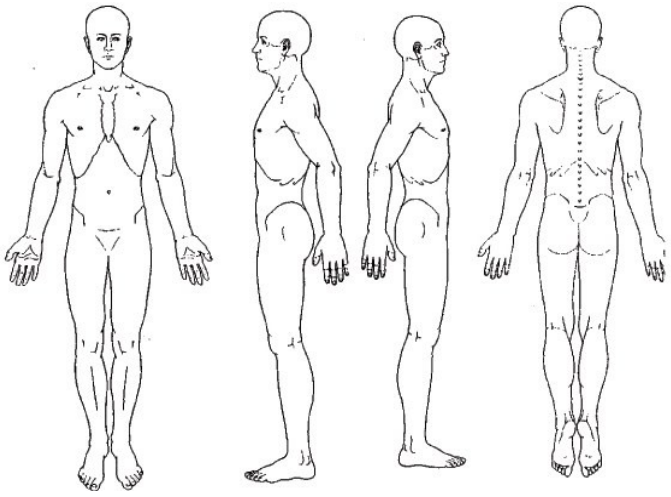
What brought you into our clinic today?_____

_____

Date this complaint originally began_____ Date current episode began_____

Please indicate on the diagram below where you are feeling your pain or discomfort, including any radiating or referred symptoms. Also mark what kind of pain or discomfort you are feeling.

Where is your pain?



What does the symptom feel like?

□ Dull □ Achy □ Sharp □ Burning

□ Numbness □ Shooting □ Throbbing □ Nagging

□ Stiffness □ Cramps □ Tingling □ Stabbing

One a scale of 0 to 10, rate your pain:
(0 = no pain, 10 = worst pain ever felt)

Pain level currently_____

Pain level at it's worst_____

Pain level at it's best_____

Pain level average_____

What activities increase the pain or discomfort? _____

What activities decrease the pain or discomfort?_____

What part of the day are the symptoms worse? _____

What part of the day are the symptoms better? _____

Past Medical History

List any disease, major illness or any other health conditions past or present:_____

_____

List all drugs/medications and supplements with dosage you currently take: _____

_____

List all hospitalizations and/or surgeries and dates: _____

_____

List all injuries and accidents resulting in severe sprains, strains, whiplash, fractures, dislocations, etc.:

_____

List your primary care physician or any additional specialist visited in the last year and reason for visit:

_____

Family and Social History

List all health conditions in your family:_____

Do you smoke? □ Yes □ No Smokeless tobacco? □ Yes □ No Quantity _____

Do you use: alcohol/coffee/tea/soda/energy drinks? □ Yes □ No Quantity _____

Do you: exercise/drink water/have balanced diet? □ Yes □ No Quantity _____

Terms of Acceptance

Baltuska Chiropractic DOES NOT accept any form of health insurance, including Medicare. Your health insurance is a contract between you and your insurance company and you are expected to pay at the time that a service is rendered. Upon request we will provide you with an itemized bill that you may submit to your health insurance company for reimbursement. Baltuska Chiropractic will not be held responsible if you are not reimbursed by your health insurance company.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, 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.

We consider the privacy of your health information to be one of the most important elements in our relationship with you. Our responsibility to maintain the confidentiality of your health information is one that we take very seriously.

Federal legislation concerning patient privacy requires health care providers, health insurance companies and other health-related organizations to bolster their privacy as of April 14, 2003

Signing below is our Acknowledge Form and the Notice of Health Information Privacy Practices are offered at request. We are pleased to provide this information to our patients and to comply with the privacy regulations of the federal Health Insurance Portability and Accountability Act (HIPPA).

_____	_____	_____
Patient Name (Print)	Patient (Guardian) Signature	Date