AdventHealth Whole Health Institute

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CHIROPRACTIC INTAKE FORM

Please complete the following form to provide us with the background information we require to ensure you receive comprehensive care. This form must be completed prior to your first appointment and can be faxed to 913-632-3559 or securely emailed to SOP.WholeHealthInstitute@AdventHealth.com

To reschedule or cancel your appointment, call 913-632-3550.

Name:_____ Age: _____ DOB:_____

Gender:_____ Marital Status: _____ Primary Phone: _____

Primary Address:

_____

Email: _____

Occupation:_____ Employer:_____

Emergency contact:_____Relationship:_____Phone:_____

How did you hear about our clinic?

New patient: ☐ Yes ☐ No Appointment Date: _____ Time: _____

Referred by: _____

Please list any physicians whose care you are currently under:

_____

_____

What are your primary health concerns that you'd like to address today?

_____

_____

☐ **I agree to enroll into FullScript** as a new patient at the Whole Health Institute to receive supplement recommendations from my provider.

***FullScript** is a virtual supplement dispensary and a comprehensive platform that integrative healthcare professionals use to dispense the best quality supplements.

Please list medications and/or supplements you are currently taking and why:

Medication/Supplement	Dosage/Frequency	Medication Purpose

Please list if you have any allergies (food, medication, seasonal, such as pollen etc.)

_____

_____

PRESENT CONDITION ASSESSMENT

List conditions in order of concern	Pain Scale	Date of Onset
1.	minor 1 2 3 4 5 6 7 8 9 10 extreme	
2.	minor 1 2 3 4 5 6 7 8 9 10 extreme	
3.	minor 1 2 3 4 5 6 7 8 9 10 extreme	
4.	minor 1 2 3 4 5 6 7 8 9 10 extreme	
5.	minor 1 2 3 4 5 6 7 8 9 10 extreme	

Are any of the above condition(s) related to:

□ Sports Injury

□ Auto Accident

□ Job Related

□ Other: _____

Who have you seen for this condition?

□ Chiropractor

□ Medical Doctor

□Physical Therapist

□ Other: _____

□ No one

When did your symptoms begin? (approximate date): _____

Have any of the above conditions changed since onset? ☐Yes ☐ No

If so, please indicate which ones: _____

What makes the pain better?

_____

What makes the pain worse?

_____

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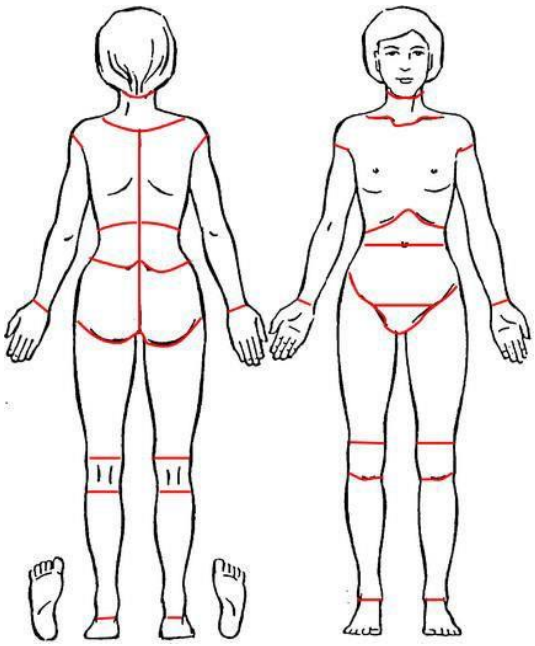
Please indicate on the figures where you have any of the following using the scale below:

A = Ache
SF = Stiffness
SH = Sharp
S = Soreness
N = Numbness
P = Pain
C = Constant
XX = Other



Please check if you are currently experiencing any of the following symptoms:

☐ Allergies	☐ Headaches	☐ Muscle Spasms	☐ Tingling in Arms
☐ Arm Pain	☐ Indigestion	☐ Neck Pain	☐ Tingling in Legs
☐ Breathing Troubles	☐ Joint Swelling/Pain	☐ Numbness in Fingers	☐ Toe Numbness
☐ Circulatory Problems	☐ Knee Pain	☐ Pregnancy	☐ Vomiting
☐ Constipation	☐ Leg Cramps	☐ Ringing in Ears	☐ Weakness in Legs
☐ Dizziness	☐ Loss of Smell/Taste	☐ Shoulder Pain	☐ Other
☐ Fatigue	☐ Low Back Pain	☐ Sinus Problems	
☐ Fever	☐ Mid Back Pain	☐ Sleep Problems	

Do you consume any of the following? Please indicate approximate amount

Water ☐ Yes ☐ No Amount _____
Soda ☐ Yes ☐ No Amount _____
Caffeine ☐ Yes ☐ No Amount _____

Alcohol ☐ Yes ☐ No Amount _____
Smoke ☐ Yes ☐ No Amount _____
Exercise ☐ Yes ☐ No Amount _____

Please indicate the following qualities regarding sleep.

Sleep: Duration: ☐ <6 hours ☐ 6-8 hours ☐ 8+ hours
Sleep Quality: ☐ Good ☐ Fair ☐ Poor

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Have you ever undergone any surgeries? ☐ Yes ☐ No

If so, please indicate which surgeries were performed and when:

_____

_____

_____

MEDICAL HISTORY Please check any condition that you or your immediate family have been diagnosed with.

	Self	Sibling	Mom	Dad		Self	Sibling	Mom	Dad
ADD/ADHD					Depression				
Arthritis					Diabetes				
Blood Pressure					Headaches				
Cancer					Heart Disease				
High Cholesterol					Varicose Veins				
Chronic Fatigue					Weight Gain/Loss				
Convulsion					Stroke				

Please identify how any of your current conditions is affecting your ability to carry out activities that may be routinely part of your life.

Walking	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Standing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Running	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Pushing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Reading	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Gardening	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Dancing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Shoveling	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Sleeping	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Doing Chores	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Rolling Over	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Watching T.V.	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Playing Sports	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Sitting	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Sitting to Standing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Computer Work	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Sexual Activity	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Bending	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Lifting	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Carrying	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Dressing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Working	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Driving	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Climbing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Concentrating	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Recreation	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform

Office Location
AdventHealth Whole Health Institute is located on the AdventHealth South Overland Park campus.
Address: 7840 W. 165th Street, Suite 110, Overland Park, KS, 66223 Phone: 913-632-3550 / Fax: 913-632-3559
Email: SOP.WholeHealthInstitute@AdventHealth.com

Virtual Visits
Now offering virtual follow up visits. Patients must physically be in the state of KS and/or MO at the time of the visit.

Directions
From the North:
Take 69 Highway to 159th Street exit. Turn right or west on 159th Street. Get in the left lane and take the second left (Panera is on one corner; bank on the other corner) at the stoplight which is Lowell Avenue. Head South on Lowell avenue and go around 2 roundabouts and enter the AdventHealth South Overland Park campus. Go past the Emergency Department and head down the hill to the Medical Office Building (7840 W. 165th Street). Enter the building, the Whole Health Institute is Suite 110 and just to the left of the elevators on the ground floor.

From the South:
Take 69 Highway to the 159th Street exit. Turn left or west on 159th Street passing over the highway. Get in the left lane take the second left (Panera is on one corner; bank on the other) at the stoplight which is Lowell Avenue. Head South on Lowell avenue and go around 2 roundabouts and enter the AdventHealth South Overland Park campus. Go past the Emergency Department and head down the hill to the Medical Office Building (7840 W. 165th Street). Enter the building, the Whole Health Institute is Suite 110 and just to the left of the elevators on the ground floor.

Charges
Your initial visit will last 60 to 90 minutes, depending on which Provider you schedule with. Follow up visits are charged based on time. Follow up visits can be booked for 30 to 60 minutes. Cash, checks, credit cards, HSA and FSA, are all accepted for services rendered, but we do not accept insurance. Payment is due on the day of service.

Arriving for your scheduled appointment
As a new patient, please plan to arrive 15 minutes prior to your scheduled appointment. This will ensure all the needed paperwork and documentation is completed prior to your appointment. The WHI providers value your time and will do everything possible to start your visit on time. This intake form MUST be completed and submitted BEFORE your scheduled appointment. If it is not completed, we may ask to reschedule your appointment.

Late Policy
You are expected to arrive 15 minutes prior to your scheduled appointment. If you are going to be 15 minutes late to your scheduled appointment time, we may request to reschedule your appointment and will be based on providers discretion and patient schedule. If you are 15 minutes late or more and are seen by the provider, you will be charged the full amount of your originally scheduled appointment, regardless of start time. If you arrive to your scheduled appointment time but have not completed and signed this intake form, we may request to reschedule your appointment.

Phone Policy
If you have a question that can be answered by a staff member, simply call the office, and ask for assistance. The staff member may consult with your WHI provider and return your call. We also encourage that each patient gets registered into the AdventHealth patient portal to communicate with the WHI providers.

Cancellation Policy
As a courtesy, phone call reminders are made whenever possible. If you must cancel, please do so 48 hours before your appointment so we can offer that appointment slot to other patients. You can call the clinic at 913-632-3550 to change or cancel an appointment. **Cancellations made less than 24 hours of the scheduled appointment time may be billed for the full appointment.**

Insurance
We do not currently file insurance for your visits. If you have a flex spending account or a health care savings account, you are encouraged to submit your visit. Your supplements may also be covered by your health care savings or flex spending account.

Labs
The WHI provider may need lab work to better understand your case. Coverage often depends upon where the labs are drawn and if they are considered medically necessary. Please look into your policy by calling your insurance company before your visit. The WHI offers many specialty lab tests, including nutritional assays, hormonal testing, digestive function testing, food allergy/intolerance testing, neurotransmitter testing, genetic testing, etc. These tests may or may not be covered by your insurance. You will need to check with your insurance to determine coverage.

You will not get specialty lab coverage through Medicare or Medicaid.

Supplements
Supplements (vitamin, minerals, herbs and homeopathy) are recommended on a case by case basis. Please be advised that we do not currently dispense supplements.

***FullScript** is a virtual supplement dispensary and a comprehensive platform that integrative healthcare professionals use to dispense the best quality supplements. The WHI providers will enroll all patients into their dispensary upon registering as a new patient and send supplement recommendations to you via the FullScript patient dashboard.

Consultations with other doctors
The WHI providers may consult with other doctors and professionals regarding your case. We encourage you to keep your primary care provider and other physicians involved in your care.

You may be contacted by phone. If you have special contact instructions, please let us know at the time of visit. For follow up questions, lab results, and other general information, you will be contacted by a member of the staff. They will consult with a WHI provider before answering your questions if needed. If you need immediate assistance, call the office, and inform a member of the staff. Phone messages are generally answered within 24 business hours. If you need to speak with someone right away, we will do everything we can to schedule an emergency visit. If that is not possible or appropriate, we may refer you to urgent care. If you have an emergency when the office is closed, please call 911.

Communications from the Whole Health Institute
As a patient of the Whole Health Institute, we want to make it easy for you to receive information on upcoming events, program offerings, articles, and/or recipes provided by your Whole Health Institute care team. By signing this document, you agree to receive email notifications that offer additional wellness resources.

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I, _____ (or the patient named below for whom I am legally responsible), hereby request and consent to receive integrative and holistic medical care by a Whole Health Institute provider. I understand that the methods of treatment may include but are not limited to nutritional counseling, western herbs, stress management tools, and nutritional supplements.

The herbs, and nutritional supplements (which are from plant, animal, mineral, and other sources) that have been recommended, are considered safe when taken as instructed in the practice of integrative and holistic medicine. It is extremely important that one follow the prescribed recommendations when taking herbs and nutritional supplements because they may be toxic when taken in large doses. I understand that some herbs and supplements may be inappropriate during pregnancy or breastfeeding, and I will immediately notify the doctor if I become aware that I am pregnant. I will also keep my WHI provider and my other health care providers informed about all the medications, herbs and supplements I take to minimize risk of interaction.

I have read and understand these policies.

Patient/Guardian Signature_____

Printed Name _____

Date: _____/_____/_____

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Chiropractic Consent

PATIENT NAME: _____

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment
The primary treatment used by a Doctor of Chiropractic is spinal manipulative therapy. The Doctor may use that procedure to treat you. The Doctor may use his/her hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment
As a part of the analysis, examination, and treatment, you are consenting to the following procedures: Spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis, ultrasound, hot/cold therapy, electrical muscle stimulation, and/or radiographic studies (x-rays).

The material risks inherent in chiropractic treatment
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray (if applicable). Stroke and /or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of a vertebral artery stroke.

The availability and nature of other treatment options
Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and painkillers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care physician.

The risks and dangers attendant to remaining untreated
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE
I have read the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Patient's Name: _____

Patient's Signature: _____

Signature of Parent or Guardian (if patient is a minor): _____