West Charleston Chiropractic Pe nal Information Form – 6212 West Charl n Suite 100, Las Vegas, NV 89128
Telephone 702-877-6767 Fax 702-877-6434 email: DrHansen6212@yahoo.com www.drhansenlasvegas.net

★DENOTES REQUIRED INFORMATION ★Date:_____

PLEASE PRINT

★Patient First Name: _____ ★Last Name:_____

Middle Name: _____ Nick Name: _____

★Address:_____ ★City: _____ ★State: ___ ★Zip: _____

★Home phone: _____ ★Cell phone: _____

★Email: _____@_____

(pick one) Preferred Method of Contact Method: email / phone / cellphone / mail via usps / no contact please

PERSONAL INFORMATION ★Date of Birth: _____ Age:____ ★Social Security # : _____

★Gender: ◯ Male ◯ Female ★Marital Status: ◯ Single ◯ Married ◯ Other

Employment Status: ◯ Employed ◯ FT Student ◯ PT Student ◯ Retired ◯ Other ◯ Self Employed

★Race: _____ ★Preferred language: _____ Referred by: _____

★(pick one) Please: ◯Hispanic or Latino ◯Not Hispanic or Latino

★(pick one) FOR ACCESS TO MEDICAL RECORDS via my Patient Portal through ChiroTouch :

◯ I choose to DECLINE RECEIPT of clinical summaries sent to my email after every visit at this office.

◯ I choose to RECEIVE clinical summaries sent to my email after every visit to this office. Note: If you choose to have copies of your records an email will be sent to you to sign up for your patient portal (your user name will be your email and your temporary password will be your birthdate in mmddyyyy format (you will need to change this to a new password once you access your patient's portal)

EMPLOYMENT INFORMATION:

★Occupation: _____ ★Employer Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Work Phone:_____

Spouse or Guardian's Name:_____

Social Security #_____ Date of Birth:_____

Employer_____ Occupation_____

Work Phone:_____ Address_____

IN CASE OF EMERGENCY CONTACT: _____ Relationship_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

★Patient Signature (or Guardian)_____ Chart Number:_____

WEST CHARLESTON CHIROPRACTIC
Dr. Kipling G Hansen
6212 West Charleston Blvd. #100, Las Vegas, NV 89146
702-877-6767 fax 702 877-6434

HIPAA (Health Insurance Privacy & Portability Act of 1996)
NOPP (Notice of Privacy Practices for Protected Health Information April 15, 2003 – 45 DFR 164.520)

As per the notice of privacy practices, West Charleston Chiropractic must provide the patient with an opportunity to agree or disagree to the use or disclosure of patient health information to a patient's family members, friends, or acquaintances involved in their care.

This document will serve as a written agreement between patient _____
And West Charleston Chiropractic as a list of those designated by the patient as having direct involvement in the patient's care and therefore allowed to access the patient's information.

In the event you are unable to sign a medical release for your records, please provide us with a list to include your next of kin and/or persons names and numbers who you will authorize us to release your medical records to. It will be the patient's responsibility to update this list as necessary.

NAME	PHONE	RELATIONSHIP

____ yes ____no **I would/would not give my permission to leave Medical information on my answering machine, email or cell phone or with the person answering the phone. (please initial)**

____ yes ____no **I would/would not like a written copy of my HIPAA rights (please initial)**

I hereby authorize West Charleston Chiropractic to use or disclose my personal health information to the above mentioned for the purpose of my care or payment related to my treatment at this office. This information may also be used for the purpose of notifying, or assist in notification of (including identifying or locating) a family member, personal representative or another person responsible for my care, of my location and/or condition.

_____ _____ _____

PATIENT SIGNATURE DATE CHART

A. Notifier: West Charleston Chiropractic/ Dr. Kipling G. Hansen, DC

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** ↓ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** ↓ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Chiropractic Manual Manipulation of the Spine	**Medicare deems visit to be not medically necessary.**	**$60.00**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** ↑ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** ↑ listed above. I may be asked to pay now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** ↑ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** ↑ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

West Charleston Chiropractic *INFORMED CONSENT FORM* – 6212 West Charleston Suite 100, Las Vegas, NV 89128
Telephone 702-877-6767 Fax 702-877-6434 email: DrHansen6212@yahoo.com www.drhansenlasvegas.net

ACKNOWLEDGEMENTS for (patient printed name) _____

NO INSURANCE: ____ (initials) I have no insurance or do not want to use my insurance.

PAYMENT VERIFICATION: I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered and non-covered services I receive. In the event of default on any payment due (Insurance or Cash), I agree to pay all costs of collection including attorney fees.

INSURANCE INFORMATION: My Primary Insurance is:_____

My Secondary Insurance is: _____

WORK VERIFICATION: ____(initials) I hereby declare my Treatment is NOT RELATED to a WORK INJURY

AUTO ACCIDENT VERIFICATION: ____(initials) I hereby declare my Treatment is NOT RELATED to an AUTO ACCIDENT

CHIROPRACTIC CARE: I instruct Dr. Kipling G Hansen to deliver the care that, in his professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

PRIVACY VERIFICATION: I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

PERMISSION TO CONTACT: I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

X-RAY VERIFICATION (FEMALES): I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant and I understand the risks.

INFORMED CONSENT TO TREATMENT: I certify that I'm the patient or legal guardian listed above. I have read/understand the information I have just filled out and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of my health information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm fully responsible for timely payment of services. I understand and agree that health/accident insurance policies are an arrangement between and insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature: _____ Date_____

Chart #_____

West Charleston Chiropractic *HEALTH INFORMATION FORM* – 6212 West Charleston Suite 100, Las Vegas, NV 89128
Telephone 702-877-6767 Fax 702-877-6434 email: DrHansen6212@yahoo.com www.drhansenlasvegas.net
(note: office personal will initial any additional information recorded on this questionnaire during initial visit)

Date:_____ ★**DENOTES REQUIRED INFORMATION** **PLEASE PRINT**

★Patient First Name: _____ ★Last Name:_____

★Describe #1 problem: _____ ★Onset date of problem: _____
★On a scale of 0-10 , rate the intensity: Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest
What is the nature of your Symptoms: ◯Dull ◯Sharp ◯Throbbing ◯Burning ◯Deep ◯Aching ◯Tingling
◯Stabbing ◯Cramping ◯Numbness ◯Radiating How often do you experience symptoms : ◯Constant ◯On & Off
To what areas does the pain radiate, shoot or travel: _____
What makes it better or worse? (Times of day, movements, activities): _____

★Describe #2 problem: _____ ★Onset date of problem: _____
★On a scale of 0-10 , rate the intensity: Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest
What is the nature of your Symptoms: ◯Dull ◯Sharp ◯Throbbing ◯Burning ◯Deep ◯Aching ◯Tingling
◯Stabbing ◯Cramping ◯Numbness ◯Radiating How often do you experience symptoms : ◯Constant ◯On & Off
To what areas does the pain radiate, shoot or travel: _____
What makes it better or worse? (Times of day, movements, activities): _____

★Describe #3 problem: _____ ★Onset date of problem: _____
★On a scale of 0-10 , rate the intensity: Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest
What is the nature of your Symptoms: ◯Dull ◯Sharp ◯Throbbing ◯Burning ◯Deep ◯Aching ◯Tingling
◯Stabbing ◯Cramping ◯Numbness ◯Radiating How often do you experience symptoms : ◯Constant ◯On & Off
To what areas does the pain radiate, shoot or travel: _____
What makes it better or worse? (Times of day, movements, activities): _____

★How do you think your problems began: (include any recent falls, bumps, etc.) _____

_____

Any other problems _____

★ **Is this injury or illness work related? ◯Yes ◯No** Has your employer been notified? ◯Yes ◯No

Have you missed work because of the injury?◯Yes ◯No ..List Dates Missed:_____

★ **Is this injury related to an auto accident? ◯Yes ◯No**

Have you been under a lot of stress lately?◯Yes ◯No What aggravates your condition?_____

Have you ever seen a Chiropractor? ◯Yes ◯No Date?_____Name of Chiropractor:_____
Location:_____Reason:_____

What have you done to relieve the symptoms: ◯Prescription Medication ◯Over the counter drugs ◯Homeopathic Cures

◯Physical Therapy ◯Surgery ◯Acupuncture ◯Vitamins/Minerals ◯Massage ◯Ice ◯Heat ◯Other_____

What is your condition interfering with: ◯Work ◯Sleep ◯Daily Routine ◯Other_____

★Anything else we should know about your current condition: _____

Chart #_____

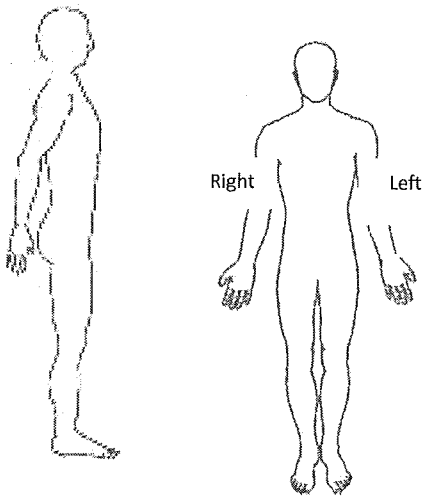
★ Denotes required information

Daily Activities: Rate the difficulty of the following daily activities on a scale of 0-10 (0 being easiest, 10 most difficult) (Mark those that apply)

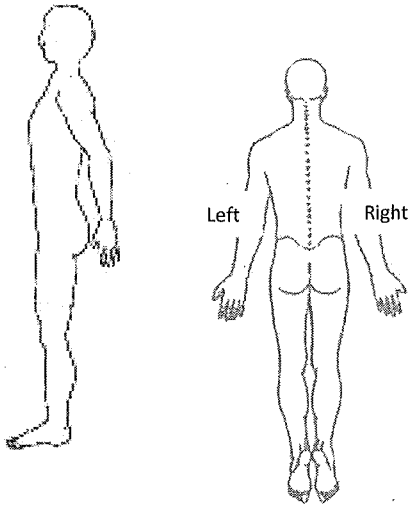
Activity	★Current Difficulty
Bending:	0 1 2 3 4 5 6 7 8 9 10
Carrying:	0 1 2 3 4 5 6 7 8 9 10
Driving	0 1 2 3 4 5 6 7 8 9 10
Housework:	0 1 2 3 4 5 6 7 8 9 10
Lifting:	0 1 2 3 4 5 6 7 8 9 10
Lying:	0 1 2 3 4 5 6 7 8 9 10
Opening jars:	0 1 2 3 4 5 6 7 8 9 10
Personal care:	0 1 2 3 4 5 6 7 8 9 10
Picking up objects:	0 1 2 3 4 5 6 7 8 9 10
Pulling:	0 1 2 3 4 5 6 7 8 9 10
Pushing:	0 1 2 3 4 5 6 7 8 9 10
Reaching:	0 1 2 3 4 5 6 7 8 9 10
Reaching behind:	0 1 2 3 4 5 6 7 8 9 10
Running:	0 1 2 3 4 5 6 7 8 9 10
Shopping:	0 1 2 3 4 5 6 7 8 9 10
Sit to stand:	0 1 2 3 4 5 6 7 8 9 10
Sitting:	0 1 2 3 4 5 6 7 8 9 10
Sleeping	0 1 2 3 4 5 6 7 8 9 10
Standing:	0 1 2 3 4 5 6 7 8 9 10
Throwing:	0 1 2 3 4 5 6 7 8 9 10
Turning Head:	0 1 2 3 4 5 6 7 8 9 10
Turning Body:	0 1 2 3 4 5 6 7 8 9 10
Walking:	0 1 2 3 4 5 6 7 8 9 10

Please mark the location: of your problems

Right side



Left side



★ CHECK ANY OF THESE SYMPTOMS YOU HAVE NOTICED:

◯Headache	◯Mid Back Pain	◯Shoulder pain	◯Loss of Balance	◯Stomach Upset
◯Neck pain	◯Mid Back Stiffness	◯Chest pain	◯Dizziness	◯Face Flushed
◯Neck stiffness	◯Mid Back spasms	◯Pins & Needles in Arms	◯Loss of Memory	◯Sleeping Problems
◯Neck muscle spasms	◯Low Back Pain	◯Pins & Needles in Legs	◯Nervousness	◯Light bothers eyes
◯Head seems heavy	◯Low Back Stiffness	◯Numbness in Fingers	◯Ringing in ears	◯Loss of Smell
◯Head hard to turn	◯Low Back spasms	◯Numbness in Toes	◯Fatigue	◯Loss of Taste

Patient Name: _____ Chart #_____

☆ Denotes required information

☆ **Has any doctor diagnosed you with Hypertension presently?** ❑ Yes ❑ No If yes, describe: _____

☆ **Has any doctor diagnosed you with Diabetes presently?** ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II ***If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?*** ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

☆ **Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?** ❑ Yes ❑ No

SMOKING HISTORY

☆ Do you currently smoke: ◯Yes ◯No----Years smoked: _____ Packs a day: _____ ◯Former Smoker

Interest in quitting on a scale of 0-10: Lowest 0 1 2 3 4 5 6 7 8 9 10 - Highest How long since you stopped: _____

STRESS INFORMATION * Denotes required information

☆ *How much physical stress are you under: Not much - 0 1 2 3 4 5 6 7 8 9 10 - A lot

☆ *How much emotional stress are you under: Not much - 0 1 2 3 4 5 6 7 8 9 10 - A lot

What are the major stressors in your life: _____

SLEEPLING INFORMATION

How many hours do you sleep per night: _____ What is your preferred sleeping position: _____

What type of mattress & pillow do you have: _____How old are your mattress & pillow: _____

HEALTHY EATING & EXERCISE INFORMATION

☆ How much regular exercise do you perform: _____ Type of exercise you perform:_____

☆ Rate your healthy eating habits: (Circle) Not healthy - 0 1 2 3 4 5 6 7 8 9 10 - Healthy

Typical eating habits: ◯Skip Breakfast ◯2 meals per day ◯3 meals per day ◯Snacking between meals

MEDICATIONS ☆ Denotes required information (use back of page if necessary)

☆ *Name: _____ Dosage: _____ *Start Date: _____

*Obtained: ◯Over the counter ◯By prescription Prescribed by: _____

Comments / used for: _____

*Name: _____ Dosage: _____ *Start Date: _____

*Obtained: ◯Over the counter ◯By prescription Prescribed by: _____

Comments / used for: _____

NUTRITIONAL SUPPLEMENTS ☆ Denotes required information

*Name: _____ Dosage: _____ *Start Date: _____

Taken with water: ◯Yes ◯No Reason for taking: _____

*Name: _____ Dosage: _____ *Start Date: _____

Taken with water: ◯Yes ◯No Reason for taking: _____

ALLERGIES * Denotes required information

☆ *Name: _____ *Start Date: _____

Medication related: ◯Yes ◯No

Symptom & Comments:_____

PAST SURGERIES (not already listed with our office)

Illness:_____ Surgery: _____

Start date:_____ End date: _____ Date:_____

PAST INJURIES (not already listed with our office)

Injury:_____ Injury:_____

Date: _____ Date:_____

 ☆ Patient Signature_____Date:_____ Chart #_____