# Jaccard Chiropractic ● Dr. Lindsey Jaccard

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**Phone**: 913-757-4044 **Fax:** 913-757-3223 **Phone:** 913-832-0131

**PATIENT INFORMATION**

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

**D.O.B.** ____/____/____ **Age:** _____ **Sex:** □ Male □ Female **Marital:** M S W D O

Address_____ City _____ State: ____ Zip _____

(1) Home Number (_____) _____ - _____ (2) Cell Number (_____) _____-_____
** ***Is it OK for this office to leave a message on these numbers*** **YES** **NO**

Current/ Past occupation:_____

Your e-mail: _____

In case of an emergency call: Name: _____ Number: _____

INSURANCE INFORMATION:
I understand that insurance is not a guarantee of payment. Deductibles and coinsurance will apply. The patient is responsible for fees not paid by the insurance company. **Initials**_____

Primary Ins. Co. Name:_____

Name of Policy Holder (if not self)_____ D.O.B. _____

Secondary Ins. Co._____

Name of Policy Holder (if not self) _____ D.O.B_____

AUTHORIZATION AND RELEASE
I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians or other healthcare providers and payors and to secure the payment of benefits. ***I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage***. I also understand that if I suspend or terminate my care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

**The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. *The following Person(s) have my permission to receive my personal health information:***_____

_____

**Patient/Guardian Signature:**_____ **Date:** _____

**MEDICAL HISTORY:**

Place a **N** for Now or a **P** for Previously, leave blank if it does not apply.

| | | |
|---|---|---|
| Headaches | Heart murmur | Hepatitis/ HIV |
| Migraines | High/ Low blood pressure | Heartburn/ reflux |
| Sinus Problems | Heart disease | Unusual bowel patterns |
| Concussion | Stroke | Blood in stools |
| Dizziness | Pacemaker | Kidney Stones |
| Back Pain/ Stiffness | Asthma | Problems with Urination |
| Neck Pain/ Stiffness | Frequent Ankle Swelling | Pregnancy |
| Joint pain/ swelling | Fatigue | Hypo/Hyper Thyroid |
| Broken/ Fractured Bone | HRT/ Birth Control | Diabetes |
| Spinal Fusion | Muscle Weakness | Anxiety/ Depression |
| Fibromyalgia | Cancer | Difficulty Sleeping |
| Epilepsy/ Seizure | History of blood clots | Other: |
| Deep Vein Thrombosis | Blood thinners | Other: |

**SOCAIL HISTORY:**

Please indicate if any of the below apply

| | |
|---|---|
| Alcohol use: Y N | Drinks / day/ week: |
| Recreational Drug Use: Y N | Frequency: |
| Chewing Tobacco/ snuff: Y N | Frequency: |
| Smoking Tobacco Y N | Frequency: |

Tobacco/Drug/ Alcohol History: Start year: _____ Quit Year: _____ Amount/ day: _____

**HISTORY OF PRESENT AND PAST ILLNESS**:

Chief complaint: What brings you into the office today? _____

_____

When did symptoms/ accident occur? _____

Please describe pain: Sharp, dull ache, strong ache, ache, constant, numbness, tingling, pinching other: _____.

What makes it better? _____

What makes it worse? _____

Please list any surgeries, accidents, major illnesses, childbirth info, congenital defects: _____

_____

_____

Please list any current prescription medications, vitamins, or other over the counter supplements:

_____

_____

Please list any allergies: _____

**FAMILY HISTORY:**

Please check any of the boxes that apply and leave those that don't blank.

| CONDITION | FATHER | MOTHER | SIBLINGS | CHILDREN |
|---|---|---|---|---|
| Arthritis | | | | |
| Asthma | | | | |
| Allergies | | | | |
| Cancer (type) | | | | |
| Diabetes | | | | |
| Epilepsy | | | | |
| Headaches | | | | |
| Migraines | | | | |
| Heart Disease | | | | |
| Bleeding disorders | | | | |
| High Blood Pressure | | | | |
| Other: | | | | |

INFORMED CONSENT:

Dr. Lindsey Jaccard will use her hands, SOT blocks or an Activator upon your body in such a way as to move your joints. This procedure is referred to as a "Spinal adjustment/ manipulation". As the joints are moved you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of an adjustment/ manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains, dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but not limited to stroke. The most common complication or complaint following a manipulation/ adjustment is an ache, stiffness or muscle soreness of the area(s) adjusted.

If needed light manual muscle work/ Active Release Technique/ massage may be done to help balance muscles to help your body maintain the adjustment as well as to help reduce muscle tension of those areas. If pressure at any time is uncomfortable, please tell Dr. Lindsey Jaccard so that she can make accommodations to you. Risk of any of these techniques may include but are not limited to bruising, sore muscles following treatment, temporary discomfort. Rare complications include but are not limited to blood clot, deep vein thrombosis. If you are on blood thinners, have cancer, on blood thinners, have a history of deep vein thrombosis or have any bleeding disorders please inform Dr. Jaccard prior to treatment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include but, are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause complication. Based upon clinical examination further imaging (CT, MRI, X-ray, Ultrasound etc.) may be required. If further imaging will be required it will be done outside this office.

Patient/ Guardian Signature: _____ Date: _____