Victory Chiropractic

134 Cherry Hill Drive
Belton, Mo 64012
(816)318-1819

Patient Name:_____ Date: _____Birth date:_____

Home Address:_____CITY:_____STATE:_____ZIP:_____

Phone: _____Spouse's Name and Phone number _____

How did you learn of this office? Google yahoo facebook friend or relative (please circle all that apply)

Height_____ Weight_____

Purpose of this visit? (wellness,complaints,etc):_____

When did your condition start?_____ Was your complaint the result of an accident?(Y N)

Did you receive any treatment for the accident? (Where and from whom)_____

Have you seen anyone else for your condition? If so please explain:_____

What makes your condition better/worse?_____
Which best describes your pain? Occasional Intermittent Frequent Constant Other please circle one

Please list any medications or vitamins _____

List any past Hospitalizations and surgeries: _____

Do you have any history of cancer, diabetes, high blood pressure, etc. ? If so please explain:
_____

Do you have a family physician? (name) _____

List your conditions and circle the best description of the severity of your condition:

1._____ No Pain 1-2-3-4-5-6-7-8-9-10 Worse

2._____ No Pain 1-2-3-4-5-6-7-8-9-10 Worse

Please mark on the drawings (next page) where you hurt and use the legend of symbols to the left to describe the pain you are experiencing. Include **ALL** affected areas.

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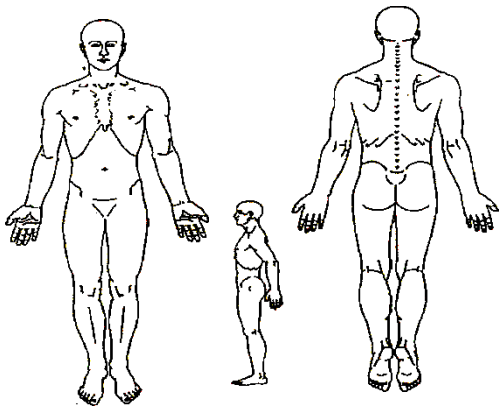

Burning=XXXXXX Aching=^^^^^^

Tingling/pins and Needles=000000

Sharp/stabbing=SSSSSS Numbness =//////

Please circle all that apply, even if it isn't related to your condition/complaint.

Head
History of head injury
Headaches
Dizziness/lightheadedness

Eyes
Eye pain
Redness/itching
Abnormal vision
Glaucoma/cataracts

Ears
Ringing in the ears
Impaired hearing
Earache

Nose/Throat
Frequent/recurrent nose bleeds
Recurrent sinusitis
Recurrent sore throat
Recurrent hoarseness

Mouth
Dental problems
Sore tongue
Sore jaw
Last dental check up_____

Neck
Thyroid problems
Swollen glands
Difficulty swallowing

Respiratory
Chronic cold/flu/cough
Asthma
Allergies
Coughing blood

Musculoskeletal
Arm/leg pain/pins and needles
Hand/foot pain/pins and needles
Back pain
Neck pain
Diagnosed arthritis

Cardiovascular
History of high blood pressure
Chest pain
Shortness of breath w/activity
Heart murmur
Heart attack
Swelling of hands or feet

Genitourinary
Lack of bladder control
Urinary frequency
Night urination frequency
Difficulty starting or stopping
Painful urination
Chronic bladder infections
Blood in urine
Kidney disease/stones
STD
Yeast infections

Gastrointestinal
Ulcers
Chronic indigestion
IBS
Gall bladder disease/stones
Hepatitis/cirrhosis
Painful bowel movements
Constipation
Diarrhea
Bloody or black stool
Hemorrhoids
Nausea
Hiatal hernia

Female
Sexual dysfunction
Birth control
Normal periods
Peri or post menopausal
History of ovarian cysts/fibroids/tumors/or endometriosis
Lumps in breast/breast pain

Male
Prostate trouble
Sexual dysfunction
Hernia
Testicular pain
Diagnosed osteoporosis

Mood
Desire psychiatric help
Frequent crying
Depression

Neurologic
Brain tumors
Spinal cord tumors
CB
Dyslexia
Epilepsy
MS
Muscular dystrophy
MG
Parkinson's
Alzheimer's/dementia

Skin
Cancer
Unusual spots/moles
other

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Dear Patient:

You have the right, as a patient, to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used, so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold you consent to the procedure.

In the practice of chiropractic there are some risks to examination and treatment procedures including, but not limited to, fractures, disk injuries, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. A rare but serious risk associated with neck manipulation is stroke.

The Doctor of Chiropractic is not able to anticipate and explain all risks and complications but relies on clinical judgment based on all the facts known at the time of the procedure, and makes decisions that, according to the facts available, are to the best interest of the patient. There are no guaranties or assurances concerning the intended results of the treatments.

The results of the examination I received at Victory Chiropractic have been explained to me. I understand the results of the examination, the proposed plan of care and the possible risks associated with the treatment. I also understand the cost of the treatment proposed.

I have read and understand the statements written on this form. I had the opportunity to ask questions to my doctor, and my questions have been fully answered. Based on this information

☐ I consent to this treatment ☐ I do not consent to this treatment

This consent covers the entire course of treatment for my present condition

_____ _____ _____

Name (please print) Signature Date

For a minor or person represented by another party:

If you sign on behalf of the patient give the description of the authority to act on behalf of the patient (parent, guardian…)

NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. There are copies in each treatment room as well as in the waiting area. If you have any questions or cannot find a copy please ask Dr. McBee immediately. By signing below you acknowledge that you have read and understand the privacy policy. Thank you Dr. Kevin McBee

_____ _____ _____

Name (please print) Signature Date

For a minor or person represented by another party.

_____ _____ _____

Name of personal representative (Please print) Signature Date