

# Rhoades Chiropractic Clinic

2215 SW Westport Dr. ◦ Topeka, KS 66614 ◦ 785-273-6531

Today’s Date: Patient Account #:

Patient Name:

Last Name First Name Middle Initial

Address: Home Phone:

City: State: Zip: Cell Phone:

Single Married Widowed Separated Divorced Work Phone:

Occupation: Employer:

Age: Birth Date: Spouse’s Name:

Responsible Party (if a Minor)

Medical Doctor’s Name:

In case of emergency, who should be notified? Name Relation to You Phone Number

Who Referred You?

What is your major complaint today?

An appointment time of 30 minutes is reserved for you. For each 30 minutes over, an additional fee of $55 will automatically be applied.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

An itemized bill to file with your insurance can be provided upon request.

I understand I am financially responsible for all charges.

I authorize the staff to perform any necessary services needed during diagnosis and treatment.

Signature: Date:

**Nutritional Informed Consent**

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term “DRUG” is definded to mean:

*“Articles intended for use in Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.”*

A vitamin is not a drug; neither is a mineral, trace element, amino acid, herb, or homeopathic remedy. Although a vitamin, mineral, trace element, amino acid, herb, or homeopathic remedy may have an effect on a disease process or symptom, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional dietary advice is not intended as a primary treatment or therapy for a disease or bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient’s diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of the spine following chiropractic adjustments.

Our practice utilizes whole food supplements and herbs to supply nutrients that support cell function and a healthy physiology. The supplements recommended are based on your unique evaluation. The cost of the supplements is not included in your evaluation fee.

By my signature below, I understand that the nutritional evaluation is a non-invasive method of analyzing the nutritional needs of my body. Nutritional deficiencies may cause or contribute to various health issues. I understand that the methods used at Rhoades Chiropractic Clinic are not to diagnose or treat any disease or other specific medical condition(s). There is no testing being performed for any specific medical condition. Further, I understand that the nutritional and/or dietary program being recommended is not guaranteed, and no assurances have been made.

By my signature below, I understand that the Nutritionist I am seeing is not a medical physician, and I am not consulting for medical, diagnostic, or treatment procedures. The services performed by the Nutritionist are restricted to helping me gain better understanding of my degree of health, so I will have greater self-awareness and be able to use a self-care program for daily living.

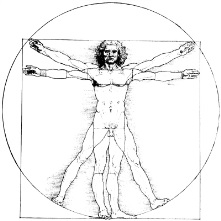
By my signature below, I authorize Rhoades Chiropractic Clinic to perform a nutritional evaluation on me for the purpose of developing a program to improve my health and not for treatment or cure of any specific disease. My evaluation will not involve the diagnosing of disease or prescribing of drugs, or any act for which a medical license is required.

I have read and understand the above:

Patient Printed Name Patient Signature Date

If patient is a minor:

Guardian Printed Name Guardian Signature Date



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Name: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any prescription medications you are currently taking or have taken in the last year.

Medications

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis (reason for taking)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any over-the-counter medications you are currently taking or have taken in the last year:

Product

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coffee

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tea

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Soft Drinks

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diet Soft Drinks

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many desserts do you have in an average week?\_\_\_\_\_\_\_\_\_

Symptom

Ice Cream

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Antacids

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Artificial Sweetener

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Quantity and Frequency

\_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_

Laxatives

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Candy

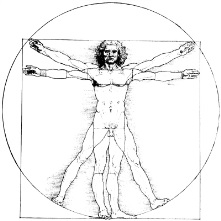
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cigarettes

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco Products

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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Do you have, or have you had, any of the following: If YES, please check.

\_\_Diabetes \_\_Recent Weight Loss

\_\_Heart Murmur \_\_Artificial Joint (hip, knee, etc.)

\_\_Rheumatic Fever \_\_Asthma or Emphysema

\_\_High Blood Pressure \_\_Prolonged Bleeding

\_\_Other Heart Aliment \_\_Ulcers

Specify:\_\_\_\_\_\_\_\_\_\_ \_\_Blood Disorders

\_\_Allergies \_\_X-Ray Therapy

\_\_Seizures, Fainting, Dizziness \_\_Hepatitis

\_\_Frequent Cold Sores \_\_Anemia

\_\_Epilepsy or Convulsions \_\_Taken Phen-fen, other prescription diet meds

\_\_AIDS, HIV \_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic, or have you reacted adversely to any of the following:

\_\_Any Anesthetic \_\_Latex

\_\_Penicillin \_\_Codeine

\_\_Cosmetics \_\_Aspirin

\_\_Any Metal \_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications now, including aspirin or alternative medicines or herbs?

Please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last physical exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you also being treated by a specialist? \_\_Yes \_\_No Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any serious illness or surgery in the past 2 years? \_\_Yes \_\_No

If so, what and when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If female, are you pregnant? \_\_Yes \_\_No Due Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any disease, condition, or problem not listed that Dr. Rhoades should know about:

Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand: Dr. Daryl Rhoades, D.C., recommends nutritional support for his patients. This in no way replaces medications prescribed by your primary care physician or any other health care professional. Medications prescribed need to be discussed with the prescribing professional before altering or discontinuing use.**

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Name (please print) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent, Guardian or Patient’s legal representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature

**This form will be placed in the patient’s chart and maintained for six years.**

List below the names and relationship of people to whom you authorize the Practice to release PHI.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_