Dr. Kara M. Birks, D.C.
804 S. Oakwood Ave. Ste. B
Geneseo, IL 61254
309-944-1213

Patient Information Sheet

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Sex: ☐ Male ☐ Female Date_____

First Name: _____ Middle Initial: _____ Last Name:_____

Address: _____

City: _____ State:_____ Zip Code:_____

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

Email Address: _____ May we contact you via Email? ☐ Yes ☐ No

Date of Birth: _____/_____/_____

Marital Status: ☐ Single ☐ Married ☐ Other

Employment Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Other

Employer_____

Emergency Contact: _____ Phone Number: _____

Relationship: _____

Patient History

Chiropractic Health History

Have you received chiropractic care in the past? ☐ Yes ☐ No If so, when?_____

Primary reason(s) for seeking chiropractic care today: _____

_____

How did you hear about Birks Chiropractic and Wellness Center?_____

_____

Past, Family, and Social History

Please list any health conditions you have experienced in the last 6 months:_____

Please list all medications that you are currently taking:_____

_____

Please list any surgeries and dates: _____

Has anyone in your family had any of the following problems? ☐ Arthritis ☐ Cholesterol

☐ Heart Problems ☐ Psychiatric Problems ☐ Thyroid ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Stroke

Please describe your occupation(s):_____

How often do you exercise? ☐ Daily ☐ Often ☐ Occasionally ☐ Rarely ☐ Never

Do you use / consume? ☐ Tobacco ☐ Alcohol ☐ Caffeine If so, how much per day?_____

Please list your hobbies or activities: _____

_____

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Review of Systems - Have you recently or in the past had any of the following?

Cardiovascular
- ☐ **No to all**

- ☐ Poor Circulation
- ☐ High Blood Pressure
- ☐ Aortic Aneurysm
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ High Cholesterol
- ☐ Pace Maker

Respiratory
- ☐ **No to all**

- ☐ Asthma
- ☐ Tuberculosis
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Cold/Flu
- ☐ Cough/Wheezing
- ☐ Sputum
- ☐ Coughing Blood

Allergic/ Immunologic
- ☐ **No to all**

- ☐ Hives
- ☐ Immune Disorder
- ☐ HIV/AIDS
- ☐ Allergy Shots
- ☐ Cortisone Use

Neurological
- ☐ **No to all**

- ☐ Stroke
- ☐ Seizures
- ☐ Head Injury
- ☐ Brain Aneurysm
- ☐ Numbness
- ☐ Pinched Nerves
- ☐ Carpal Tunnel
- ☐ Balance Problems

Gastrointestinal
- ☐ **No to all**

- ☐ Gallbladder Problems
- ☐ Bowel Problems
- ☐ Constipation
- ☐ Liver Problems
- ☐ Ulcers
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Bloody Stools
- ☐ Poor Appetite

Musculoskeletal
- ☐ **No to all**

- ☐ Gout
- ☐ Arthritis
- ☐ Joint Stiffness
- ☐ Muscle Weakness
- ☐ Osteoporosis
- ☐ Broken Bones
- ☐ Joints Replaced

Genitounrinary
- ☐ **No to all**

- ☐ Kidney Disease
- ☐ Lower Side Pain
- ☐ Burning Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Kidney Stones

Skin
- ☐ **No to all**

- ☐ Skin Lesions
- ☐ Skin Ulcers
- ☐ Skin Disease/ Cancer
- ☐ Eczema
- ☐ Psoriasis

Endocrine
- ☐ **No to all**

- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Hair Loss
- ☐ Menopausal
- ☐ Menstrual Problems

Head
- ☐ **No to all**

- ☐ Headaches
- ☐ Severe Headaches
- ☐ Migraines
- ☐ Head Injury

Ears/Nose/Throat
- ☐ **No to all**

- ☐ Hearing Loss
- ☐ Sinus Infection
- ☐ Nosebleed
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Bleeding Gums

Hematologic/ Lymphatic
- ☐ **No to all**

- ☐ Hepatitis
- ☐ Blood Clots
- ☐ Cancer
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Fevers/Chills/Sweats

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Notes: (OFFICE USE ONLY)

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STATEMENT OF FINANCIAL RESPONSIBILITY AND AUTHORIZATION TO TREAT:

I understand that I am financially responsible for all services rendered to me or my dependent at Birks Chiropractic and Wellness Center. I hereby authorize Birks Chiropractic and Wellness Center to submit claims to my insurance company or other third party on my behalf. If my insurance company denies payment on my behalf, I understand that I am financially responsible for any remaining balance.

I further authorize my insurance company to direct payment to Birks Chiropractic and Wellness Center on my behalf.

I authorize the physician to diagnose and treat me or my dependent/minor child and to use any diagnostic modality needed to make a clinical diagnosis and develop a treatment plan. I understand that results are not guaranteed.

I understand and am informed that, as in the practic of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgement during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known. I have read the above consent. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

Patient Signature:_____ Date _____

Legal Guardian's Printed Name_____ Signature_____

Translated By _____ Physician's Signature_____

Insurance Information (Please bring in insurance card)

Insurance Company: _____ Effective Date: _____ / _____ / _____

Member ID #: _____ Group #: _____

If you are not the policy holder, provide us with the following:

Holders Name: _____ Relation: _____

Date of Birth: _____ / _____ / _____

Employer_____