Wichita Kinesiology Group Wellness Clinic

5205 E. Kellogg Drive Wichita, Ks. 67218 316-684-0550
www.WKGWellness.com

Patient Data Sheet

NAME_____

SPOUSE_____

MARITAL STATUS

__☐__Married __☐__Single __☐__Divorced __☐__Widowed

BIRTHDATE_____ AGE_____

ADDRESS _____

CITY_____ STATE_____ ZIP_____

EMAIL_____

CELL PHONE_____

SPOUSE PHONE_____

REFERRED TO US BY_____

EMERGENCY CONTACTS

NAME_____RELATIONSHIP_____

PHONE_____PHONE_____

HOSPITAL PREFERENCE_____

MEDICAL DOCTOR_____

CHIROPRACTOR_____

THERAPIST_____

REFERRED TO US BY_____

PREVOUS EVENTS TO THIS APPOINTMENT

RECENT ACCIDENT OR INJURY __☐__YES __☐__NO

__☐__HOME __☐__SPORTS __☐__WORK __☐__AUTO

DATE OF INJURY_____

RECENT POST SURGERY SYMPTOMS __☐__YES __☐__NO

TYPE OF SURGERY_____

DATE OF SURGERY_____

DATES OF POST SURGERY THERAPY_____ TO _____

OTHER FORMS OF TREATMENT_____

Life Style and Activities

YOUR EMPLOYER_____

WORK TITLE_____

WORK DUTIES / ACTIVITIES_____

_____

HOURS PER WEEK_____

LAST VACATION DATE_____

RECREATION / EXERCISE ACTIVITIES

TYPE	FREQ / WEEK	INTENSITY

CURRENT or RECENT REHAB / DIET PROGRAMS

TYPE	FREQ / WEEK	INTENSITY

WHAT IS YOUR GENERAL STATE OF HEALTH?

__☐__POOR __☐__FAIR __☐__GOOD __☐__EXCELLENT

WHEN WAS THE LAST TIME YOU REALLY FELT GOOD?

_____WEEKS _____MONTHS _____YEARS

SHORT VERSION—EXPECTATION OF THIS APPOINTMENT

_____

_____

_____

_____

_____

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Patient's Current Health status

TODAY'S DATE_____ **NAME**_____ **DOB**_____

Please list current primary and secondary concerns

SYMPTOM	DATE OF ONSET	SEVERITY/FREQUECNCY	TRIGGER	TREATMENT	SUCCESS
Ex: Headache	May 2013	Mild / 3 xs per week	Exercise	Aspirin/Rest	Fair

Do you take ANY of the following substances?

PRODUCT	YES	HOW LONG?	LIST THE TYPE
Vitamin / Mineral Supplements	_____	_____	_____
Herbs / Laxatives	_____	_____	_____
Pain Meds / Muscle Relaxants	_____	_____	_____
Sedatives / Tranquilizers	_____	_____	_____
Birth Control Pills	_____	_____	_____
Hormone Replacement Therapy	_____	_____	_____
Blood Pressure Medicine	_____	_____	_____
Insulin	_____	_____	_____
Other Prescribed Medicine	_____	_____	_____
Over The Counter Products	_____	_____	_____
Recreational Drugs /CBD Oils	_____	_____	_____
Tobacco	_____	_____	_____
Alcohol	_____	_____	_____
Coffee	_____	_____	_____
Diet Soda / Artificial Sweeteners	_____	_____	_____
Bio Mat / Magnets	_____	_____	_____

Food Diary

Place a check mark next to the food/drink that applies to your current diet

Usual Breakfast	Usual Lunch	Usual Dinner
☐ None	☐ None	☐ None
☐ Bacon/Sausage	☐ Butter	☐ Beans (legumes)
☐ Bagel	☐ Coffee	☐ Brown rice
☐ Butter	☐ Eat in a cafeteria	☐ Butter
☐ Cereal	☐ Eat in restaurant	☐ Carrots
☐ Coffee	☐ Fish sandwich	☐ Coffee
☐ Donut	☐ Fried foods	☐ Fish
☐ Eggs	☐ Hamburger	☐ Green vegetables
☐ Fruit	☐ Hot dogs	☐ Juice
☐ Juice	☐ Juice	☐ Margarine
☐ Margarine	☐ Leftovers	☐ Milk
☐ Milk	☐ Lettuce	☐ Pasta
☐ Oat bran	☐ Margarine	☐ Potato
☐ Sugar	☐ Mayo	☐ Poultry
☐ Sweet roll	☐ Meat sandwich	☐ Red meat
☐ Sweetener	☐ Milk	☐ Rice
☐ Tea	☐ Pizza	☐ Salad
☐ Toast	☐ Potato chips	☐ Salad dressing
☐ Water	☐ Salad	☐ Soda
☐ Wheat bran	☐ Salad dressing	☐ Sugar
☐ Yogurt	☐ Soda	☐ Sweetener
☐ Oatmeal	☐ Soup	☐ Tea
☐ Milk protein shake	☐ Sugar	☐ Vinegar
☐ Slim fast	☐ Sweetener	☐ Water
☐ Carnation shake	☐ Tea	☐ White rice
☐ Soy protein	☐ Tomato	☐ Yellow vegetables
☐ Whey protein	☐ Vegetables	☐ Other (List Below)
☐ Rice protein	☐ Water	
☐ Other (List Below)	☐ Yogurt	
	☐ Slim fast	
	☐ Carnation/protein shake	

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No

How much of the following do you consume each week?

Candy	Diet Soda
Cheese	Ice Cream
Chocolate	Salty foods
Cups of coffee containing caffeine	Slices of white bread (rolls/bagels, etc)
Cups of decaffeinated coffee or tea	Soda with caffeine
Cups of hot chocolate	Soda without caffeine

Functional Medicine & Chiropractic Kinesiology Clinic
Symptom Survey – Check all that apply

Section 1

- ☐ Memory declining
- ☐ Difficult time remembering names, numbers
- ☐ Focus declining
- ☐ Forgot appointments
- ☐ Temperament getting worse
- ☐ Attention span getting worse
- ☐ Often sad
- ☐ Fatigued while driving or traveling than normal
- ☐ Fatigued while reading
- ☐ Forget why you walk into a room
- ☐ Think/focus better with exercise or caffeine
- ☐ I have cold hands or feet or tip of nose

Section 2

- ☐ Feel as something must be done
- ☐ Time for yourself
- ☐ Difficult to exercise
- ☐ Getting enough rest/sleep
- ☐ Feel you are not accomplishing your life's purpose
- ☐ Sharing problems is difficult

Section 3A

- ☐ Shaky, irritable or light-headed between meals
- ☐ Feel energized after eating
- ☐ Hungry in the morning
- ☐ Skip breakfast
- ☐ Difficult to eat a large breakfast
- ☐ Energy drops in the afternoon
- ☐ Crave sweets in the afternoon
- ☐ Wake up more than one during the night
- ☐ Difficulty concentrating before eating
- ☐ Depend on coffee or caffeine to keep you going or to start your day
- ☐ Have blurred vision
- ☐ Slow starter in the morning
- ☐ Afternoon headaches
- ☐ Headaches with exertion or stress
- ☐ Nails break easily

Section 3B

- ☐ Trouble falling asleep
- ☐ Gain weight under stress
- ☐ Waist is bigger than hips
- ☐ Trouble losing weight
- ☐ Need coffee after meals
- ☐ Increased appetite
- ☐ Tired after you eat
- ☐ Eating sweets relieves cravings for sugar immediately
- ☐ Urinate often
- ☐ Uncontrolled blood sugar
- ☐ A loss of stress in your life
- ☐ Sweat easily

Section 4

- ☐ Dry skin, dandruff or flaky scalp
- ☐ Consume processed, boxed or bagged foods
- ☐ Consume fried foods daily
- ☐ Trouble or don't consume fist (not fried), olive oil, or avocados

Section 5

- ☐ Difficulty digesting foods
- ☐ Constipation or inconsistent bowel movements
- ☐ Swell after eating, abdominally or in the extremities
- ☐ Bowels do not empty completely
- ☐ Hard or dry stools
- ☐ More than 3 bowel movements per day
- ☐ Foul-smelling gas
- ☐ Tongue is coated with debris
- ☐ Lower abdominal pain relieved by passing stool or gas
- ☐ Difficulty swallowing pills
- ☐ Difficulty digesting protein, starch or fat rich foods

Section 6

- ☐ Brain fog when your body is inflamed or hurts
- ☐ Pain or inflammation
- ☐ Brain fog, unclear thoughts or concentration
- ☐ Fatigue or get tired after meals and/or cannot concentrate

Section 7

- ☐ Tired after eating bread
- ☐ Feel better when you avoid grains
- ☐ Have been diagnosed with gluten sensitivity, hypothyroidism, or autoimmune disease
- ☐ A family member has been diagnosed with celiac, gluten sensitivity, hypothyroidism, or autoimmune disease
- ☐ 100% gluten free

Section 8

- ☐ Typically, cold or sluggish
- ☐ I have cold hands, feet and other parts
- ☐ Require excessive sleep to function
- ☐ Gain weight on a low-calorie diet
- ☐ Difficult bowel movements that are in frequent
- ☐ Lost eyebrow hair
- ☐ Morning headaches that wear off throughout the day
- ☐ Heart palpitations, insomnia, or night sweats
- ☐ Increased pulse, even at rest
- ☐ Difficult to gain weight

Section 9

- ☐ Difficult to move like you used to
- ☐ Takes a while to get moving after waking up
- ☐ Difficult to get up from the floor
- ☐ Jump up and down without pain or fear of falling
- ☐ Fall often

Section 10

- ☐ Increased food intolerance and/or sensitivities
- ☐ Aches and pains throughout your body
- ☐ Increased tolerances to smells, jewelry, shampoo, lotions, detergents, etc.
- ☐ Constant skin outbreaks
- ☐ Unexplained itchy skin
- ☐ Gallstones, gallbladder problems or gallbladder removed
- ☐ Reddened skin, especially the palms
- ☐ Yellowish cast to your eyes
- ☐ Bitter metallic taste in your mouth

Section 11

- ☐ Excessive burping and bloating
- ☐ Daily heartburn
- ☐ Heartburn lying down or bending forward
- ☐ Heartburn with spicy foods, chocolate, alcohol or caffeine
- ☐ Pain on your left side under the rib cage
- ☐ Heartburn subsides with rest
- ☐ Take antacids
- ☐ Gas following a meal
- ☐ Bad breath
- ☐ Hungry within two hours of eating a meal
- ☐ Avoid spicy foods, chocolate, citrus, peppers, alcohol or caffeine because it hurts

Section 12

- ☐ Difficulty digesting roughage or fiber
- ☐ Indigestion 2-4 hours after eating
- ☐ Undigested stool, mucous like, greasy or improperly formed
- ☐ Frequent loss of appetite

Section 13

- ☐ Abdominal distention after eating solids
- ☐ Bouts of alternating constipation/diarrhea
- ☐ Have been diagnosed with celiac, leaky gut, diverticulosis, or IBS

Section 14 – Women Only

- ☐ Trouble with acne
- ☐ Growing facial hair
- ☐ Hair loss or thinning hair
- ☐ Hot flashes
- ☐ Decreased libido, little or non-existent
- ☐ Intercourse is painful
- ☐ Mood swings or depression

Section 14A – Non-premenopausal Women only

- ☐ Perimenopausal
- ☐ Extended or shortened menstrual cycles
- ☐ Heavy blood flow
- ☐ Breast tenderness, pain and cramping during periods

Section 14B – Menopausal Women only

- ☐ Hot flashes
- ☐ Mental fogginess

Section 15 – Men only

- ☐ Difficult to urinate, slower flow or dribbling
- ☐ Pain inside legs or heels
- ☐ Legs twitch at night
- ☐ Libido has decreased
- ☐ Lost morning erections
- ☐ Erections have lost their fullness
- ☐ Decrease in concentration
- ☐ Sweating attacks
- ☐ More emotional that you once were
- ☐ Physical stamina significantly decreased

Section 16

- ☐ Trouble with your vision
- ☐ Vision is declining over time
- ☐ Started wearing glasses as an adult
- ☐ High blood pressure
- ☐ Difficulty handling high blood pressure

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Patient Notification

Please note... our unique scope of practice is not new experimental technology but an unorthodox integration of four specialties individually *approved by most Chiropractic Universities*. However the Kansas State Board of Healing Arts establishes what is called the "standard of care" and has mandated that some of the procedures performed in this office have been classified as "*Equivocal*" and "*Investigational*". This means that the Board of Healing Arts claims there is no current supportive research studies because the **previous and older research for this technology does not meet the current standards for today's research.**

Recipients of this care must be informed of this status and sign this consent if they wish to receive our clinical evaluations and therapeutic services.

Initials_____ **Date_____**

Consent for Examination

I will accept conservative examination procedures of visual and hands on clinical examination regarding my health concerns. I expect the doctor will touch only as necessary to perform appropriate clinical testing and perform prudent visual inspection of my body as necessary during his clinical assessment. I understand that the purpose of this examination is to determine what issues are contributing to my condition and the doctor will report his findings and recommendations. Furthermore, to monitor my vital signs and to document my clinical progress

I give permission for Dr. Milton Dowty and / or his assistant to perform assessment services .

Initials_____ **Date_____**

Consent for Examination of Minor Child

As parent and / or guardian of _____I give permission to Dr. Milton Dowty to perform conservative examination procedures of visual and hands on clinical examination.

I expect the doctor will touch only as necessary to perform appropriate clinical testing and perform prudent visual inspection of this child while performing his clinical assessment. I understand that the purpose of this examination is to determine what issues are contributing to this child's conditions and upon the completion of the evaluation he will report his findings and recommendations even if it requires electronic transmission in my absence.

I give permission for Dr. Milton Dowty and / or his assistant to monitor vital signs and document the progress.

Parent / Guardian Signature_____ Relationship_____ Date_____

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Medicare Waiver of Liability
Advanced Beneficiary Notice

This waiver includes all services in our office throughout your treatment plan.

Provider Notice to Patients

"Medicare will only pay for services that they determine to be 'reasonable and necessary' under section 1862 (a) (1) of the Medicare law. Medicare has determined that particular services are not reasonable and necessary under Medicare program standards, so Medicare will deny payment for those services. I believe that in your case, Medicare is likely to deny payment."

Beneficiary Agreement

"I have been notified by this provider that he believes that in my case Medicare is likely to deny payment for the services he needs to use to facilitate my recovery. Since Medicare denies payment, I agree to be personally and fully responsible for payment."

DATE

(Signature of Patient)

WKG Wellness Clinic

Wichita Kinesiology Group Wellness
5205 E. Kellogg Drive Wichita, KS 67218
3316-684-0550 **Tammie@wkgwellness.com**

Financial Policy

The policies for billing and filing of insurance are designed and regulated by the insurance commissioner of Kansas. Each insurance company policy has its unique coverage so please note the following…

- We do not have a contract with any insurance company…but you do!
- We no longer contact your insurance company to file for your reimbursements.
- To acquire your benefits you may need to consult your insurance carrier about your coverage.
- We will provide you with information and records so you can mail your claim to your insurance carrier and your reimbursement will be sent to your home.

If you fail to protect your copy of each session we can retrieve your records from archive for a $40 fee.

Patient Signature_____ **Date**_____

WKG Office Fees

- **New Patient Evaluation** PLUS doctor's report and initial procedures ……..$ 300.00
- **New Patient Child Evaluation** PLUS doctor's report and initial procedures …..$ 180.00
- **6 Month Reactivation Exam** PLUS doctor's report and initial procedures ……..$ 180.00
- **3 Month Reactivation Exam** PLUS doctor's report and initial procedures ……..$ 110.00
- **Active Case Evaluation** PLUS doctor's report and initial procedures ……..$ 95.00