The Khoury Centre for Chiropractic & Wellness

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PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Khoury Chiropractic Inc.'s *Notice of Privacy Practices for Protected Health Information.*

Patient Name Printed _____ Date _____

Patient Signature _____

Witness Name Printed _____ Date _____

Witness Signature _____

Confidential Patient Health Record

PERSONAL HISTORY

Name: _____ Business Employer: _____

Address: _____ Type of Work: _____

City: _____ Work Phone: _____

State: _____ Zip/Postal Code: _____ Cell:_____

Home Phone Number: _____ Email Address:_____

Would you like to receive email appointment reminders? Yes No

Which phone number do you prefer we use to contact you? _____ Would you like to receive our newsletters? Yes No

Date of Birth: _____ Age: __ Sex: □ M □ F Circle One: Single Married Widowed Divorced Separated

Race:_____ Ethnicity:_____ Language: _____

Current Employment:_____ Start date:_____

Height: _____ Weight: _____

Social Security Number: _____ Name Of Spouse (If applicable): _____

Drivers License Number: _____ Name of Emergency Contact: _____

Referred To This Office By: _____ Phone Number of Emergency Contact: _____

□ Personal Health Insurance Co.: _____ □ Health Card Number: _____

Insured Person's Name:_____ Insured Person's Date of Birth: _____

CURRENT HEALTH CONDITION

Reason for Visit: _____

Other Doctors Seen For This Condition: □ Yes □ No If Yes Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin?_____ Has the Condition Occurred Before? □ Yes □ No

Is Condition: □ Job Related □ Auto Accident □ Home Injury □ Fall □ Other: _____

Date of Accident: _____ Have You Made A Report Of Your Accident To Your Employer: □ Yes □ No

Are you being treated for low back pain? □ no □ yes -date you were diagnosed_____

Do you have diabetes? □ no □ yes if yes, date diagnosed:_____ by: (Physician's name)_____

Do you have high blood pressure? □ no □ yes -date you were diagnosed_____ by:_____

Name of Primary Care Physician (PCP):_____

PCP Address: _____

Do You Wear a Shoe Lift? □ Yes □ No

Please list your current medications, date started, type, strength, dosage, duration, and prescribing doctor. Use the back of this page if necessary

_____

_____

Have you had any tests in the last year (lab, x-ray, MRI etc) please list test and result:

_____

_____

Do you smoke? □ no □ yes- how much/often _____

Do you have allergies?: □ no □ yes- to what? _____ what is your reaction?_____

Do you drink coffee: □ no □ yes how much:_____ Do you drink: alcohol: □ no □ yes how much:_____

Do you use drugs: none recreationally addicted Do you exercise: never daily weekly walks run swim

PAST HEALTH HISTORY

Patient Name:_____

Previous Chiropractic Care: □ None □ Doctor's Name & Approximate Date of Last Visit:_____

Major Surgery/Operations: please list surgery, date, and result:_____

_____

Major Accidents Or Falls (please note when): _____

_____

Hospitalization (other than above please list date, reason, and hospital):

_____

_____

Family history: please list family member, condition:

Relationship	Disease(s) or condition(s)	Deceased ?	Cause of death
_____	_____	□ Yes □ No	_____
_____	_____	□ Yes □ No	_____
_____	_____	□ Yes □ No	_____
_____	_____	□ Yes □ No	_____

_____

Confidential Patient Health Record

"GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTION TEST"

Instructions: Please check the correct response.

Historical Information

- Have you ever been diagnosed or told you have any of the following?
  1. High Blood Pressure (hypertension) □ Yes □ No
  2. Hardening of the arteries (arteriosclerosis) □ Yes □ No
  3. Diabetes □ Yes □ No
  4. Heart or blood vessel diseases □ Yes □ No
  5. Bone spurs on the neck bones (cervical spondylosis) □ Yes □ No
  6. Whiplash injury (flexion-extension injury) (cervical spine) □ Yes □ No
  7. Have any of your relatives suffered a stroke? □ Yes □ No
  8. Were you ever a smoker? If yes, from _____ to _____ □ Yes □ No
  9. Do you take any medications on a regular basis? □ Yes □ No
     - You will be asked to list these on page 3
  10. (Women Only) Have you ever taken oral Contraceptives? □ Yes □ No
     - If yes, from _____ to _____
- Have you ever had any of the following, even short, temporary attacks, in the last year?
  1. Blurred Vision □ Yes □ No
  2. Double Vision □ Yes □ No
  3. Diminished or partial loss of vision in one or both eyes? □ Yes □ No
  4. Complete loss of vision in one or both eyes? □ Yes □ No
  5. Ringing, buzzing or any noise in the ear(s)? □ Yes □ No
  6. Hearing loss in one or both ears? □ Yes □ No
  7. Slurred speech or other speech problems? □ Yes □ No
  8. Difficulty swallowing? □ Yes □ No
  9. Dizziness? □ Yes □ No
  10. Temporary lack of understanding? □ Yes □ No
  11. Loss on consciousness, even momentary blackouts? □ Yes □ No
  12. Numbness or loss of sensation in the face, fingers, hand, arms, legs, or any other parts of your body? □ Yes □ No
  13. Any other abnormal sensations in any part of your body? □ Yes □ No
  14. Weakness, clumsiness or loss of strength in the face, finger, hands, arms, or legs? □ Yes □ No
  15. Sudden collapse without loss of consciousness? □ Yes □ No

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Below is a list of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect you overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD and write in approximately when:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

Have you been tested HIV Positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODES

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____

FEMALES ONLY

When was your last period?

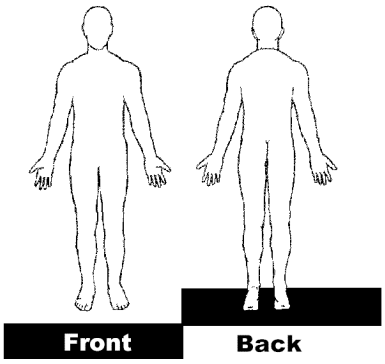
_____

Are you Pregnant?

☐ Yes ☐ No

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever



Please outline on the diagram the area of your discomfort

The above health history and information is complete and accurate. If a new symptom or condition arises during my treatment I will notify the doctor as soon as possible.

_____

Patient Name Printed

_____ _____

Patient Signature Date

WORKER'S COMPENSATION QUESTIONNAIRE

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information in order to determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your accident properly, please be as neat and accurate as possible while completing this form. Thank you.

Name_____

Employer's Name_____ Employer's Phone_____ City_____

Occupation_____

Give time and date present injury occurred_____□ AM □ PM _____20_____

Has this accident been reported to your employer? □ Yes □ No. When? _____

To Whom? _____

Please explain in detail how your accident happened_____
_____
_____
_____
_____
_____

Where did you feel pain immediately after the accident? _____

If you were taken to the hospital, which one? _____

Have you lost time from work as a result of this accident? □ Yes □ No
If yes, when was your last day worked? _____

Are you being compensated for time lost from work? □ Yes □ No

Did you return to work? □ Yes □ No If yes, date returned to work? _____

Did you consult any other doctor? □ Yes □ No

If yes, doctor's name_____ □ D.C. □ M.D. □ D.O. □ D.D.S.
Diagnosis _____

What treatments did you receive?_____

In your work do you have to favor any part of your body? □ Yes □ No
If yes, explain _____

Do you have a history of absenteeism caused from accidents on the job? □ Yes □ No

Have you ever had a Workmen's Compensation claim before? □ Yes □ No

Before the injury were you capable of working on an equal basis with others of your age? □ Yes □ No

Are your work activities restricted as a result of this accident? □ Yes □ No

Since the injury occurred, are your symptoms: □ Improving □ Getting Worse □ Same

Have you retained an attorney? □ Yes □ No Litigation □ Yes □ No □ Maybe
If so, name and address _____

Have you ever injured this area before? □ Yes □ No If so, when? _____

If injured before, did you lose time from work? □ Yes □ No

If you lost time from work with injuries prior to this injury, give name of doctor or doctors consulted ___
_____
_____
_____

Do any other diseases or accidents affect your employment? □ Yes □ No If yes, explain _____
_____
_____

Do you have any congenital (from birth) factors or previous illness, which relate to this case? □ Yes □ No
If yes, describe _____
_____

Have you ever been involved in an accident before? If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received _____
_____
_____

What type of treatment did you receive? _____
_____

Date _____ Patient's Signature
_____

WORKERS COMPENSATION INSURANCE INFORMATION

NAME _____ **DATE**_____

YOUR EMPLOYER'S INSURANCE INFORMATION

NAME OF EMPLOYER_____

INSURANCE COMPANY NAME _____

ADDRESS_____

PHONE # _____ ADJUSTER__ _____ FAX # _____

CLAIM #_____

ATTORNEY INFORMATION

NAME _____

ADDRESS _____

_____ PHONE _____

PERSONAL HEALTH INSURANCE

INSURANCE COMPANY _____

ADDRESS_____

PHONE # _____

Please provide our receptionist with a copy of your health insurance card.

I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER OR ATTORNEY INVOLVED IN MY CASE.

(Please read the above paragraph carefully before signing.)

_____ _____

SIGNATURE DATE

WITNESS _____