Kalee Norman Chiropractic

Personal Information

Name:_____
First Initial Last

Address:
_____
Street City State Zip

Home Phone: _____

Cell Phone: _____

Work Phone: _____Ext. _____

Email:_____

SSN: ___-___-_____ Date of Birth: ___/___/_____ Sex: ___

Occupation: _____Employer: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Spouse's Name/Number:
_____

Emergency Contact:
_____
Name Number Relationship

How will you be covering the cost of care?
□Self-Pay
□Insurance Carrier:_____ ID#:_____ Group#:_____
□Personal Injury: Attorney:_____ and/or Claim#:_____
□Other: _____

How were you referred to our office?
_____

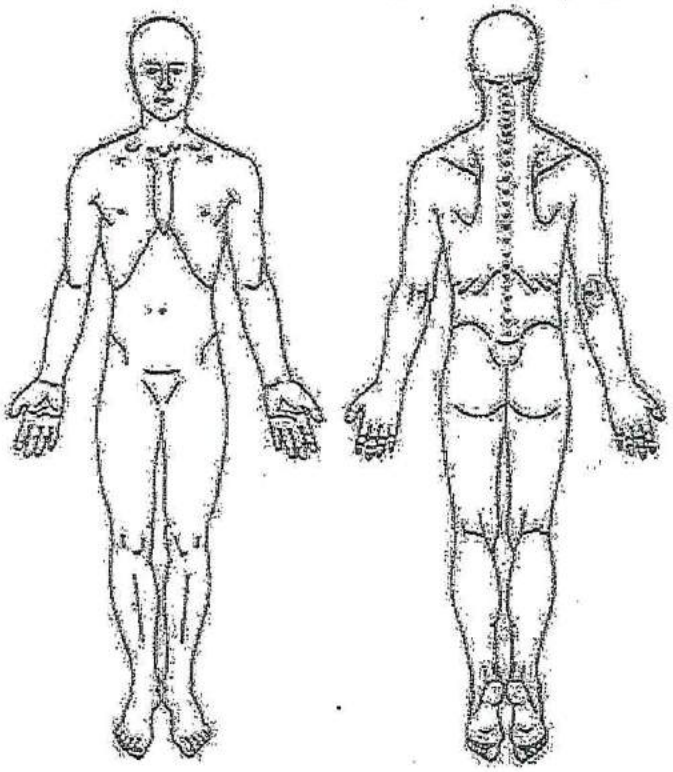
Health Questionnaire

Name:_____ Date:_____

A. Complaints:

Using the key below, indicate on the body diagram where you are experiencing your symptoms:

N = Numbness B = Burning S = Stabbing T = Tingling A = Aching



Describe your symptoms in order of severity, with worse symptoms being #1:

_____

_____

_____

When did your symptoms begin? Date: _____

How would you rate your pain today? (0 = No pain, 10 = worst pain ever)

0 1 2 3 4 5 6 7 8 9 10

Is your condition due to:

- □ An automobile accident?
- □ A work-related injury?
- □ Other: _____

How often do your symptoms occur?

□ Occasional □ Intermittent □ Frequent □ Constant □Other:_____

Is your complaint aggravated by any of the following?

□ Coughing □ Sneezing □ Bowel Movements □ Lifting
□ Bending □ Sitting □ Standing □ Walking
□ Reaching □ Neck Movement □ Driving □ Exercise
□ Other: _____

Is your complaint relieved by any of the following?

□ Rest □ Ice □ Heat □ Stretching □ Exercise
□ Sitting □ Standing □ Laying down □ Sleeping
□ Nothing □ Other: _____

Since your symptoms began, have there been any changes to the following:

□ Bowel Function: Onset Date:_____ Duration: _____
□ Bladder Function: Onset Date:_____ Duration: _____
□ Sexual Function: Onset Date:_____ Duration: _____

B. Review of Systems:
Are you presently suffering from, or have suffered from any of the following?

General: □ Fatigue □ Weakness □ Fever □ Sleep loss □ Chills
□ Weight Loss □ Night Sweats

Neurological: □ Headache □ Dizziness □ Fainting □ Convulsions □ Double Vision

Mouth/Throat: □ Sores □ Bleeding □ Enlarged Glands □ Loss of taste
□ Abnormal taste □ Change in smell □ Difficulty swallowing

Heart/Lungs: □ Cough □ Difficulty Breathing □ Swollen arms/legs
□ Blue discoloration □ Varicose veins □ Murmur □ Chest pain
□ Heaviness in legs with walking □ Heart Palpitations

Gastrointestinal: □ Decreased appetite □ Increased Appetite □ Vomiting
□ Abdominal pain □ Hemorrhoids □ Diarrhea □ Constipation

Genitourinary: □ Inability to hold urine □ Painful urination □ Bedwetting □ Impotence
□ Frequent Urination □ Irregular menstruation □ Painful menses
□ Prostate problems □ Loss of bowel/bladder control

Endocrine: □ Intolerance to heat □ Intolerance to cold □ Tremors □ Neck Lump
□ Sugar in urine □ Diabetes □ Constant fatigue

Psychological: □ Anxiety □ Depression □ Memory loss □ High stress
□ Mood swings □ Mental impairment □ Phobias

Are there any other symptoms not listed above that you are experiencing?
Please List: _____

Social History

Smoking:	□ Never	□ Occasional	□ Often: Packs/Day: _____
Alcohol:	□ Never	□ Occasional	□ Often: Drinks/Day: _____
Exercise:	□ Never	□ Occasional	□ Often
Caffeine Use:	□ Never	□ Occasional	□ Often

C. Medical History

Have you been to a Chiropractor before? ☐ Yes ☐ No

Do you have a family physician? ☐ Yes ☐ No
Physician's name/address: _____
Date of last physical exam: _____

Do you have any allergies and/or allergic reactions to medications?
☐ No ☐ Yes (Please list) _____

Please list any medications you are currently taking:

_____

_____

Women Only:
Are you or could you be pregnant at this time? ☐ Yes ☐ No
Do you regularly see an OB-GYN? ☐ Yes ☐ No

Please check any condition you currently have or have had in the past:

☐ Arthritis ☐ Diabetes ☐ Thyroid issues ☐ Cancer
☐ Scoliosis ☐ Epilepsy ☐ HIV/AIDS ☐ Heart trouble
☐ High Blood pressure ☐ Pacemaker ☐ Multiple Sclerosis (MS)
☐ Osteoporosis (DJD) ☐ Depression ☐ STI's
☐ Other: _____

To your knowledge, does your family history include any of the following conditions?
☐ Cancer ☐ Stroke ☐ Arthritis ☐ Diabetes ☐ Heart Disease
☐ High Blood Pressure ☐ Rheumatoid Arthritis ☐ Thyroid Issues ☐ Other:_____

Occupation Information – Activities of Daily Living

Job Type: ☐ Full Time ☐ Part Time ☐ Temporary ☐ Other: _____

Work Week: Hours/Day: 1 2 3 4 5 6 7 8 9 10 11 12 13+
(Circle one) Days/Week: 1 2 3 4 5 6 7

What activities does your job involve? (Mark all that apply)
☐ Sitting ☐ Typing ☐ Lifting – Weight_____ ☐ Walking
☐ Twisting ☐ Bending ☐ Reaching ☐ Stooping

What is your primary work position/location? (Mark one)
☐ Seated ☐ Standing ☐ Both equally

Is there anything not covered in the questionnaire that you feel is important for the doctor to know?

_____

_____

Lake Norman Chiropractic

Patient's Name: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES LAKE NORMAN CHIROPRACTIC CENTER, P.A. TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to Lake Norman Chiropractic Center, P.A. to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday-related cards, information about treatment alternatives or other health related information.

If Lake Norman Chiropractic Center, P.A. contacts me by phone, I give them permission to leave a phone message with a member of my household and/or my answering machine/voicemail.

I give Lake Norman Chiropractic Center, P.A. permission to treat me in an area where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

I give Lake Norman Chiropractic Center, P.A. permission to use my first initial and last name on their internal referral board if and when I refer people to their office for evaluation and treatment.

By signing this form, you are giving Lake Norman Chiropractic Center, P.A. permission to use and disclose your protected health information in accordance with the directives listed above.

This notice is effective as of the date of the signed authorization. This authorization shall expire seven years after the date on which you last received services from Lake Norman Chiropractic Center, P.A.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this authorization by mailing or hand delivering a written notice to the privacy official of Lake Norman Chiropractic Center, P.A. The written notice must contain the following information:

- Your name, social security number, and date of birth
- A clear statement of your intent to revoke this authorization
- The date of your request
- Your signature

The revocation is not effective until it is received by our compliance/privacy officer.

This authorization is requested by Lake Norman Chiropractic Center, P.A. for its own use/disclosure of private health information.

You have the right to refuse to sign this authorization. If you refuse to sign, Lake Norman Chiropractic Center, P.A. will not refuse to provide treatment.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON REQUEST

Print Name: _____

Signature: _____

Date: _____

Signature of parent/guardian: _____

Relationship to patient: _____

Informed Consent Form

PATIENT NAME: _____ **DATE:** _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask for clarification before you sign.

The nature of the chiropractic adjustment

The primary treatment procedure used by Doctors of Chiropractic is spinal manipulative therapy. The doctor may use his/her hands or a mechanical instrument on your body in such a way as to create motion in joints. This procedure may cause an audible "pop" or "click"; similar to what you experience when you "crack" your knuckles. You may feel an increased sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures in order for the doctor to make the most accurate diagnosis and provide the most effective treatment for your condition:

□Spinal Manipulative Therapy	□Radiographic Studies	□Heat Therapy
□Range of Motion Testing	□Palpation	□Cold Therapy
□Muscle Strength Testing	□Orthopedic Testing	□Vital Signs
□Therapeutic Ultrasound	□Postural Analysis	□Electrical Stimulation
□Mechanical Traction	□Neurological Testing	□Soft Tissue Massage

□ Other: _____

_____

The material risks inherent in chiropractic treatment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strains, cervical myelopathy, ligament sprains, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the upper cervical spine leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment, this is not uncommon. The doctor will make every reasonable effort during the examination to screen for contraindications to care. However, if you have a condition that would otherwise not come to the doctor's attention, it is your responsibility to inform him/her.

The probability of those risks occurring

Fractures are a rare occurrence and generally result from an underlying weakness of the bone which the doctor will check for during your history, the exam, and X-rays. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and estimated to occur between one in one million and one in five million neck adjustments. The other complications listed are generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care/prescription drugs such as anti-inflammatory, muscle relaxers, and pain-killers
- Hospitalization
- Surgery
- Other manual therapies such as massage, acupuncture, or physical therapy

If you choose to use one of the above "other treatment options", you should be aware that there are risks and benefits involved with such options and you may wish to discuss these with your primary care physician.

The risks and dangers to remaining untreated

Remaining untreated may allow for the formation of scar tissue and a loss of mobility. If left to progress, this could potentially lead to a cascade of pain reactions and further reduction of mobility causing more permanent changes to your joints and soft tissues. Over time this process may complicate future treatment making it more difficult and less effective as the damage builds up the longer it is postponed.

DO NOT SIGN THIS UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION

PLEASE CHECK THE APPOPRIATE BOX AND SIGN BELOW

☐ **I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed any questions/interpretations with the doctor and had them answered to my satisfaction. By signing below, I state that I have compared the risks and benefits involved in receiving chiropractic treatment and have decided that it is in my best interest to undergo the treatment recommended by the doctor. Having been informed of the procedures, risks, and benefits, I hereby give my consent to receive treatment.**

Date: _____ **Date:** _____

_____ _____

Patient's Name **Doctor's Name**

_____ _____

Patient's Signature **Doctor's Signature**

_____

Signature of Parent/Guardian (if a minor)