Northwest Chiropractic Patient Case History

Today's Date _____ First Name: _____ Last Name: _____

Nick Name: _____ Birth Date: _____ Gender: _____ SSN: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail: _____ Preferred Communication: **email** / **phone** / **text** Preferred Language:_____

Emergency Contact: Name: _____ Relationship: _____ Phone: _____

Allergies (Check all that apply)

☐ None ☐ Other: _____

____ Animals ____ Aspirin ____ Bees ____ Chocolate ____ Dairy

____Dust ____ Eggs ____ Latex ____ Molds ____ Penicillin

____ Ragweed/Pollen ____ Rubber ____ Seasonal Allergies ____ Shellfish ____ Soaps

____ Wheat ____ X-Ray Dye

Current Medications

Medication	Reason	Start Date

Surgeries (Check all that apply)

☐ None ☐ Other: _____

__ Ankle	__ Appendix	__Back	__ Bladder	__ Brain/Tumor	__ Chest	__ Cleft Pallet
__ EENT	__ Elbow	__ Eye	__ Finger	__ Foot	__ Gallbladder	__ Gastrointestinal
__ Hand	__ Heart	__ Hip	__ Hysterectomy	__ Kidney	__ Knee	__ Leg
__ Mastectomy	__ Neck	__ Obstetrical	__ Prostate	__ Shoulder	__ Wrist	

Medical History (Check all that apply)

☐ None ☐ Other: _____

__ Acid Reflux	__ Ankle Pain	__ Arm Pain	__ Arthritis	__ Asthma	__ Autoimmune Disorder
__ Back Pain	__ Broken Bones	__ Cancer	__ Chest Pain	__ Cluster Headaches	__ Heart Defect
__ COPD	__ Depression	__ Diabetes	__ Dizziness	__ Elbow Pain	__ Epilepsy
__ Eye/Vision Problems	__ Fainting	__ Fatigue	__ Fibromyalgia	__ Foot Pain	__ Genetic Spinal Disorder
__ Glaucoma	__ Gout	__ Hand Pain	__ Headaches	__ Hearing Problems	__ Hepatitis
__ Hiatal Hernia	__ High Blood Pressure	__ Hip Pain	__ HIV	__ Hyperthyroidism	__ Hypothyroidism
__ Irritable Bowel Syndrome	__ Jaw Pain	__ Joint Stiffness	__ Kidney Stones	__ Knee Pain	__ Leg Pain
__ Low Back Pain	__ Major Heart Problems	__ Menstrual Problems	__ Mid Back Pain	__ Minor Heart Problems	__ Multiple Sclerosis
__ Neck Pain	__ Neurological Disorder	__ Osteoporosis	__ Parkinson's Desease	__ Polio	__ Prostate Problems
__ Restless Leg Syndrome	__ Ruptured Disk	__ Scoliosis	__ Shingles	__ Shoulder Pain	__ Significant Weight Change
__ Sinus Problems	__ Sleep Apnea	__ Spinal Cord Injury	__ Sprain/Strain	__ Stomach Problems	__ Stroke/Heart Attack
__ Tumor	__ Ulcers	__ UTI	__ Wrist Pain		

Have you had any auto or other accidents? ☐ No ☐ Yes

Describe: _____

Date of last physical examination: _____ Do you smoke ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes – how many per day? _____

Do you drink caffeine? ☐ No ☐ Yes – how many per day? _____

Do you exercise? ☐ No ☐ Yes – what forms and how often _____

What are your hobbies? _____

Who may we thank for referring you? _____

Have you ever had chiropractic care? ____ No _____ Yes Where? _____

When? _____ Why? _____

Were X-rays taken? _____No ____Yes When was your last adjustment? _____

What is your main reason for consulting the office?

___ Become pain free.
___ Explanation of my condition
___ Learn how to care for my condition.
___ Reduce symptoms.
___ Resume normal activity level.

Family History

List your family History: Example: Maternal Grandmother – High Blood Pressure

_____

_____

_____

_____

_____

MAJOR COMPLAINT

1. What is your Major complaint? _____ Date problem began: _____
2. How did this problem begin (falling, lifting, etc.) _____?
3. How is your condition changing? __ Getting Better __ Getting Worse __ Not Changing
4. Have you had this condition in the past? ____ Yes ____ No
5. How often do you experience your symptoms? ____ Constantly (76-100% of the day)

____ Frequently (51-75% of the day) ____ Occasionally (26-50% of the day) ____ Intermittently (0-25% of the day)

6. Describe the nature of your symptoms: __ Sharp __ Dull __ Numb __ Burning __ Shooting __ Tingling

__ Radiating Pain __ Tightness __ Stabbing __ Throbbing __ Other: _____

7. Please rate your pain on a scale of 1-10 (0= no pain and 10= excruciating pain) 1 2 3 4 5 6 7 8 9 10
8. How do your symptoms affect your ability to perform daily activities such as working or driving?

   (0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10
9. What activities aggravate your condition (working, exercise, etc)? _____
10. What makes your pain better (ice, heat, massage, etc)? _____

COMPLAINT #2

1. What is your second complaint? _____ Date problem began: _____
2. How did this problem begin (falling, lifting, etc.) _____?
3. How is your condition changing? __ Getting Better __ Getting Worse __ Not Changing
4. Have you had this condition in the past? ____ Yes ____ No
5. How often do you experience your symptoms? ____ Constantly (76-100% of the day)

___ Frequently (51-75% of the day) ___ Occasionally (26-50% of the day) ___ Intermittently (0-25% of the day)

6. Describe the nature of your symptoms: __ Sharp __ Dull __ Numb __ Burning __ Shooting __ Tingling

__ Radiating Pain __ Tightness __ Stabbing __ Throbbing __ Other: _____

7. Please rate your pain on a scale of 1-10 (0= no pain and 10= excruciating pain) 1 2 3 4 5 6 7 8 9 10
8. How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

9. What activities aggravate your condition (working, exercise, etc)? _____
10. What makes your pain better (ice, heat, massage, etc)? _____

COMPLAINT #3

1. What is your third complaint? _____ Date problem began: _____
2. How did this problem begin (falling, lifting, etc.) _____?
3. How is your condition changing? __ Getting Better __ Getting Worse __ Not Changing
4. Have you had this condition in the past? ____ Yes ____ No
5. How often do you experience your symptoms? ____ Constantly (76-100% of the day)

____ Frequently (51-75% of the day) ____ Occasionally (26-50% of the day) ____ Intermittently (0-25% of the day)

6. Describe the nature of your symptoms: __ Sharp __ Dull __ Numb __ Burning __ Shooting __ Tingling

__ Radiating Pain __ Tightness __ Stabbing __ Throbbing __ Other: _____

7. Please rate your pain on a scale of 1-10 (0= no pain and 10= excruciating pain) 1 2 3 4 5 6 7 8 9 10
8. How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

9. What activities aggravate your condition (working, exercise, etc)? _____
10. What makes your pain better (ice, heat, massage, etc)? _____

CANCELLATION POLICY

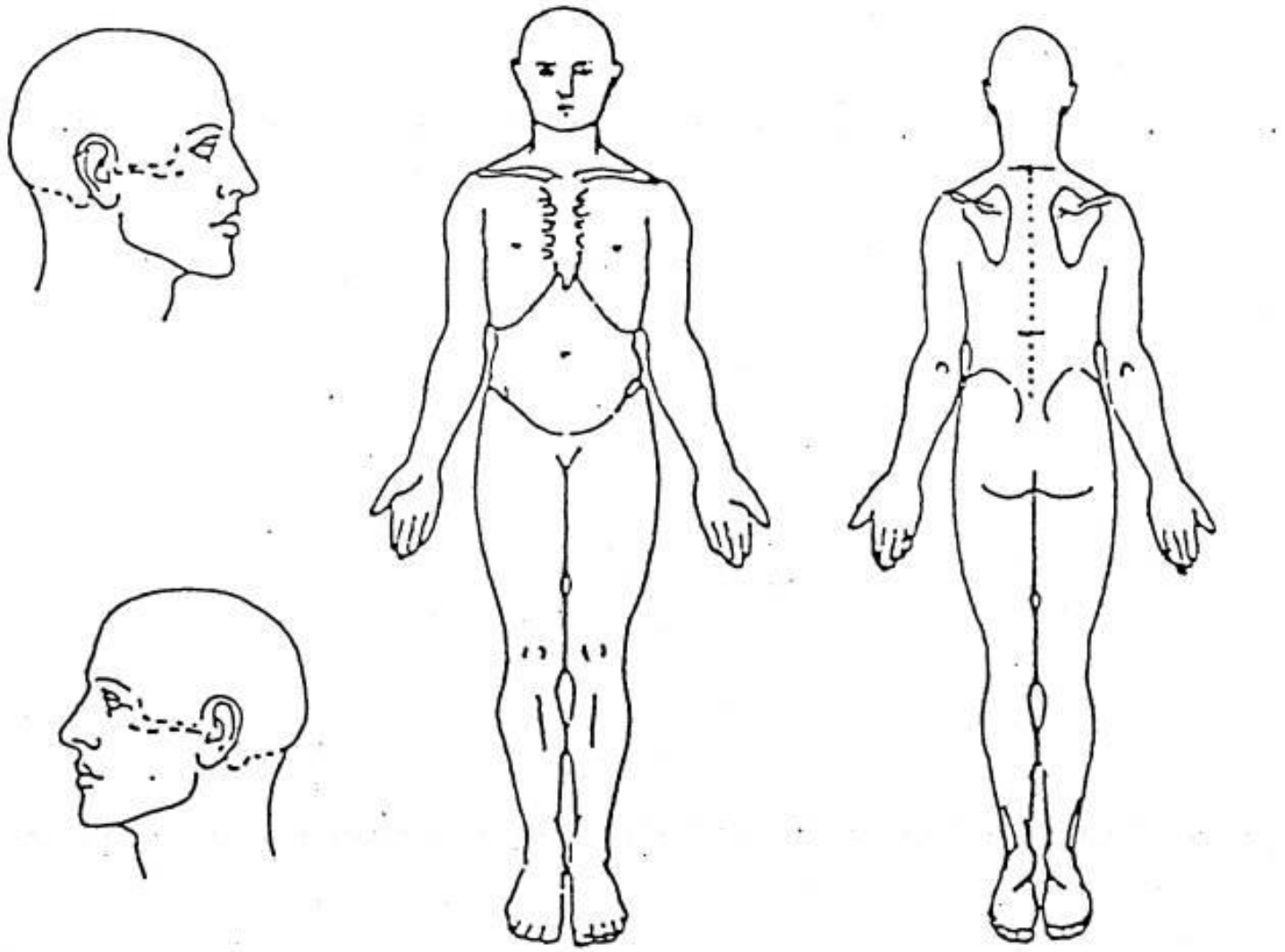
We require a 12-hour notice for cancellations. If we do not receive notice of cancellation before your scheduled appointment, we will assess a $25 NO SHOW fee. In order to stay on time and give each patient their scheduled time, we reserve the right to reschedule your appointment if you are more than 10 minutes late.

I have read and understand the cancellation policy.

_____

Patient Signature

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



INFORMED CONSENT

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 questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to some if not all the following procedures:

Spinal manipulative therapy, palpitation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis, ultrasound, hot/cold therapy, Electrical Stim, Radiographic studies, mechanical traction.

Other: (Please explain) _____

The material risks inherent in chiropractic adjustment.

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 strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I 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 my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also 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 and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with you primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK 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 it with Dr. Kelly McLaurin and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ **Dated:** _____

_____ _____

Patient’s Name **Doctor’s Name**

_____ _____

Signature **Signature**

_____

Signature of Parent or Guardian (if a minor)

Northwest Chiropractic
Kelly S. McLaurin, DC
725 Cranberry St.
Newland, NC 28657
(828) 733-4848

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

Get an electronic or paper copy of your medical record
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

ONLY if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200

Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- **Treat you**
  We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- **Run our organization**
  We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
- **Bill for your services**
  We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and, preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you for workers' compensation claims, for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective September 23, 2013

_____ _____

Patient Signature *Date*