

# Chiropractic Partners

Phone: (919) 572-2312

Fax: (919) 572-2437

5007 South Park Drive, Suite 130

Durham, NC 27713

## CONFIDENTIAL HEALTH QUESTIONNAIRE

Please complete this form as accurately as possible. Your answers will help us determine whether chiropractic can help you. If we do not sincerely believe your condition can respond satisfactorily, we will not accept the case. Thank you for your cooperation.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

Address: \_\_\_\_\_ City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alternate #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

(Please Circle) Male or Female Marital Status: M S W D Spouse's Name: \_\_\_\_\_

Do you have any children?  Yes  No If yes, how many? \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

What name would you like to be called in our office? \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Who is responsible for payment of the bill? \_\_\_\_\_

Physical activity at work:  No Manual Labor (sedentary)  Light Manual Labor  Moderate Manual Labor  Heavy Manual Labor

How would you grade your general stress level?  No Stress  Minimal Stress  Moderate Stress  Greatly Stressed

### Current Problems

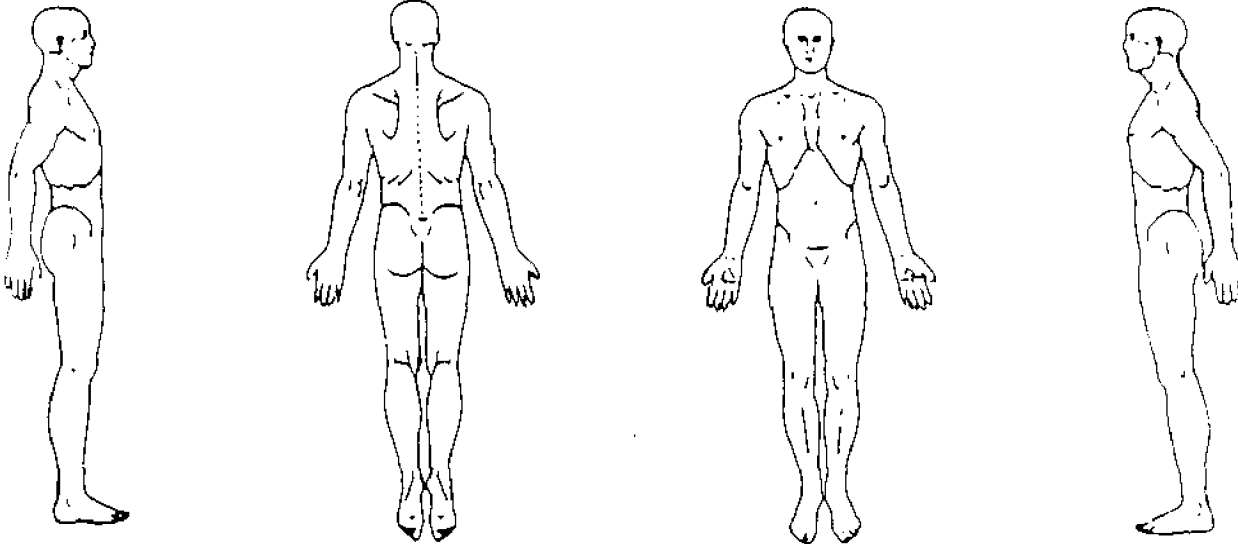
What kinds of problems are you having today? \_\_\_\_\_

When did this problem begin? (Specific date if possible): \_\_\_\_\_

Do you know how your problem began? \_\_\_\_\_

Please describe the character of your current pain (Check all that apply):  Sharp/Stabbing  Sharp/Dull  Aches  Dull  
 Soreness  Weakness  Throbbing/Gnawing  Numbness  Shooting  Gripping/Constricting  Burning  Tingling

PLEASE MARK AN "X" ON THE BODY BELOW WHERE YOU HAVE PAIN OR DISCOMFORT, INCLUDING NUMBNESS OR TINGLING



How often are the symptoms present?  Constant (76-100%)  Frequent (51-75%)  Occasional (26-50%)  Intermittent (25% or less)

How bad is the pain or ache? (Please circle one) 0 1 2 3 4 5 6 7 8 9 10  
No Pain Unbearable Pain

Since your symptoms began, has the pain:  Increased  Decreased  Not Changed

What makes your symptoms better?  Nothing  Lying Down  Walking  Standing  Movement/Exercise  Inactivity

Other: \_\_\_\_\_

What makes your symptoms worse?  Nothing  Lying Down  Walking  Standing  Movement/Exercise  Inactivity

Other: \_\_\_\_\_

Are your complaints affecting your ability to work or otherwise be active?  Yes  No If yes, please check the one you are closest to:

Need limited assistance with everyday tasks  Have a significant inability to function without assistance

Some physical restrictions (need assistance often)  Totally disabled (impaired). Cannot care for self.

Have you consulted other doctors for these symptoms?  Yes  No If yes, please list the name, date(s) seen, and any treatments given: \_\_\_\_\_

Is this the first time you've had these symptoms?  Yes  No If no, were you previously treated for these symptoms?  Yes  No If yes, please specify dates and type of treatment: \_\_\_\_\_

**Past Medical History**

Name and Address of Medical Doctor: \_\_\_\_\_ Dr. Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date of last: Physical Exam \_\_\_\_\_ Blood Pressure Check \_\_\_\_\_ X-Rays \_\_\_\_\_

List any current medications: \_\_\_\_\_

List any surgeries with dates: \_\_\_\_\_

Are there any illnesses in your family?  Yes  No If yes, please specify: \_\_\_\_\_

Any prior auto, work, or other accidents?  Yes  No If yes, please give dates and details: \_\_\_\_\_

General physical activity:  No Regular Exercise  Light Regular Exercise  Strenuous Exercise

**Please check the appropriate box if any of the following apply to you (past or present)**

<u>GENERAL</u>	Severe	Mod	Mild	<u>GASTROINTESTINAL</u>	Severe	Mod	Mild	<u>DO YOU HAVE:</u>	Yes	No
Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Colds/Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>RESPIRATORY</u>				Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Breakdown	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
				<u>MUSCLE &amp; JOINT</u>						
<u>GENITO-URINARY</u>				Ankle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>FOR WOMEN ONLY</u>		
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arm/Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Inability to Control Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elbow Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Cycle	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Infection or Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot Trouble/Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumps in Breast	<input type="checkbox"/>	<input type="checkbox"/>
Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Menstruation	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
				Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>HABITS</u>		
<u>CARDIO-VASCULAR</u>				Pain between Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea _____ Cups/Day		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco _____ Pack(s) / _____		
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rib Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol _____ Drinks / _____		
Swelling of Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep _____ Hrs/Night		

To the best of my knowledge, the preceding answers to the questions on this form are the complete truth regarding my health history.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

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## ASSIGNMENT, LIEN AND AUTHORIZATION INSURANCE BENEFITS AND ATTORNEY

To Whom It May Concern:

I hereby authorize and direct you, the insurance company and/or my attorney, to pay directly to Chiropractic Partners (hereunder described as "The Clinic") such sums as may be due and owing The Clinic for services rendered me, both by and reason of accident, of illness and by reason of any other bills that are due The Clinic, and to withhold such sums from any disability benefits, medical payment benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment, or verdict on behalf as may be necessary to adequately protect The Clinic. I hereby further give a Lien to The Clinic on any and all insurance benefits named herein, and on any and all settlements, judgments or verdicts which I have been treated by The Clinic. This is to act as an Assignment of my rights and benefits to the extent of the services, supplements, supports and equipment of any kind provided by The Clinic.

I understand that I remain personally responsible for the total amounts due The Clinic for all services and goods it has rendered and given. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for The Clinic to await payments and that The Clinic may demand payments from me immediately upon rendering services or providing related goods such as The Clinic deems appropriate.

I authorize The Clinic to release any information pertinent to my case to any insurance company, managed care organization, attorney or adjuster to facilitate collection under this Assignment, Lien and Authorization. I agree that The Clinic be given power of Attorney to endorse/sign my name on any and all checks for payment of The Clinic's bills. I further understand and agree that if The Clinic must take action to collect any outstanding balances on my account, I will be held responsible for payment of them and will reimburse The Clinic for all costs incurred by such collection efforts including but not limited to all court costs and all attorney fees. This lien is regulated by: NCGS 44-49 and NCGS 44-50.

Date: \_\_\_\_\_

Patient/Guardian Sign: \_\_\_\_\_

Witness: \_\_\_\_\_

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## **CONSENT OF USE OR DISCLOSURE OF HEALTH INFORMATION**

### **Our Privacy Pledge**

We are very concerned with your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we have to use or disclose our health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent for (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

### **Your Right to Limit Uses or Disclosure**

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree to your restrictions, the restriction is binding on us.

### **Your right to revoke your authorization**

You may revoke your consent at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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## **INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE**

To be completed by patient or patient's legal representative, if necessary, e.g., if patient is a minor or physically or legally incapacitated:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays on me (Or on the patient named below, for whom I am legally responsible) by Dr. Arturo Presas and/or other licensed doctors of chiropractic who now or in the future treat me while employed by working with or associated with servicing as back up for the doctor of chiropractic named above, including those working at the clinic or office listed or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time based on facts then known, is in my best interests.

During your examination, the doctor may feel that x-rays will be needed in order to fully diagnose your condition and administer proper treatment. In order to perform x-rays on any patient, our office requires patient consent for such procedures to be performed.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about the consent, and by signing below I agree to the above named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Signature (Patient or Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (Print Name)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Date of last menstrual cycle: \_\_\_\_\_