KURTZ CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of KURTZ CHIROPRACTIC Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient's Name DOB

_____ _____

Patient or Authorized Person's Signature Date

_____ _____

Witness Date

KURTZ CHIROPRACTIC Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at KURTZ CHIROPRACTIC have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____

Patient Name (print)

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date

APPLICATION FOR CARE AT KURTZ CHIROPRACTIC

PATIENT DEMOGRAPHICS **Todays date:_____-_____-_____**

Name: _____ Birthdate: _____-_____-_____ Age: _____ ○ Male ○ Female

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

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

E-mail Address: _____ Marital Status: ○ Single ○ Married ○Widow

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____Relationship: _____

I depend on referrals to keep overhead low and pass the savings on to you who may I thank for referring you? _____

Name of previous chiropractor: ○ N/A _____ Good experience? Yes No

If Yes, time under care: _____ months / years When was your last adjustment? _____ months / years

Reason for discontinuing care? _____ Is your problem the result of ANY type of accident? ○ Yes ○ No

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*****:**

Primary or chief complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin?_____

When is the problem at its worst? ○ AM ○ PM ○ mid-day ○ late PM _____

How long does it last? ○ It is constant **OR** ○ I experience it on and off during the day **OR** ○ It comes and goes throughout the week

How did the injury happen?_____

What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Condition(s) ever been treated by anyone in the past? ○ No ○ Yes **If yes,** when? _____

by whom? _____How long were you under care?_____

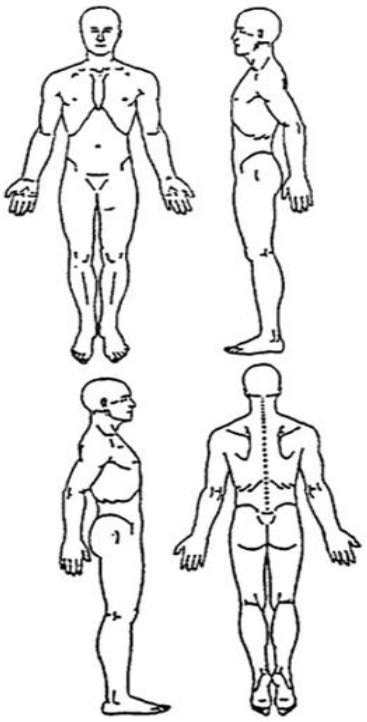
What were the results?_____

Have you suffered with any of this or a similar problem in the past? ○ No ○ Yes **If yes,** how many times? _____When was the last episode?_____ How did the injury happen? _____

Other forms of treatment tried: ○ No ○ Yes **If yes,** please state what type of treatment: _____, and who provided it_____

How long ago? _____ What were the results. ○ Favorable ○ Unfavorable

Please explain: _____



PLEASE MARK the areas on the body diagram to the right with the following letters to describe your symptoms: **R = R**adiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling

ACTIVITIES OF DAILY LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life.

No Effect = Leave BLANK A = Painful but doable B = Painful with limits C = Unable to Perform

Carry Children/Groceries	○A ○B ○C	Shaving	○A ○B ○C	Sweeping/Vacuuming	○A ○B ○C
Sit to Stand	○A ○B ○C	Sexual Activities	○A ○B ○C	Dishes	○A ○B ○C
Climb Stairs	○A ○B ○C	Sleep	○A ○B ○C	Laundry	○A ○B ○C
Pet Care	○A ○B ○C	Static Sitting	○A ○B ○C	Garbage	○A ○B ○C
Extended Computer Use	○A ○B ○C	Static Standing	○A ○B ○C	Driving	○A ○B ○C
Lift Children/Groceries	○A ○B ○C	Yard work	○A ○B ○C	Exercise	○A ○B ○C
Read/Concentrate	○A ○B ○C	Walking	○A ○B ○C	Other: _____	
Getting Dressed	○A ○B ○C	Washing/Bathing	○A ○B ○C	_____	

PAST HISTORY

Identify any other injury(s) to your spine, minor or major, that the doctor should know about: _____

_____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body: _____

_____

List Prescription & Non-Prescription drugs you take: _____

_____

If you have ever been diagnosed with any of the following conditions, please indicate with:

P for in the ***Past*** **C** for ***Currently*** have **N** for ***Never*** have had

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer
___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions: _____

PLEASE IDENTIFY ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE	PROVIDED BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ○ No ○ Yes **If yes,** whom?
○ grandmother ○ grandfather ○ mother ○ father ○ sister(s) ○ brother(s) ○ son(s) ○ daughter(s)
Have they ever been treated for their condition? ○ No ○ Yes ○ I don't know

2. Any other hereditary conditions the doctor should be aware of? ○ No ○ Yes: _____

SOCIAL HISTORY

1. Smoking: ○ cigars ○ pipe ○ cigarettes ○ vape ○ Daily ○ Weekends ○ Occasionally ○ Never
2. Alcoholic Beverage: consumption occurs ○ Daily ○ Weekends ○ Occasionally ○ Never
3. Recreational Drug use: ○ Daily ○ Weekends ○ Occasionally ○ Never
4. Hobbies - Recreational Activities - Exercise Regime: How does your present problem affect? (See ADL)

I understand that I am directly and fully responsible to KURTZ CHIROPRACTIC for all fees associated with chiropractic care I receive.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

KURTZ CHIROPRACTIC CLINICAL EXAMINATION FINDINGS

Patient Name: _____ DOB: _____ Date: _____

SUBLUXATION / PALPATION																						
F = Fixation / Segmental Dysfunction **P** = Pain **S**=Spasm																						
								LEFT						**RIGHT**								
Supine CC Prone						List		F	P	S	SPINE	S	P	F	List			Supine CC Prone				
					TMJ	AS	PS				Occ				AS	PS	TMJ					
						ASL					C1					ASR						
						PL	BL				C2				PR	BR						
						PL	BL				C3				PR	BR						
						PL	BL				C4				PR	BR						
						PL	BL				C5				PR	BR						
						PL	BL				C6				PR	BR						
						PL	BL				C7				PR	BR						
List	F	P	S	Extrem	Rib	PL	PRI-t				T1				PR	PLI-t	Rib	Extrem	S	P	F	List
				Scap	Rib	PL	PRI-t				T2				PR	PLI-t	Rib	Scap				
				SC	Rib	PL	PRI-t				T3				PR	PLI-t	Rib	SC				
				AC	Rib	PL	PRI-t				T4				PR	PLI-t	Rib	AC				
				Hum	Rib	PL	PRI-t				T5				PR	PLI-t	Rib	Hum				
				Elb	Rib	PL	PRI-t				T6				PR	PLI-t	Rib	Elb				
				Wrist	Rib	PL	PRI-t				T7				PR	PLI-t	Rib	Wrist				
				Hand	Rib	PL	PRI-t				T8				PR	PLI-t	Rib	Hand				
				Finger	Rib	PL	PRI-t				T9				PR	PLI-t	Rib	Finger				
					Rib	PL	PRI-t				T10				PR	PLI-t	Rib					
					Rib	PL	PRI-t				T11				PR	PLI-t	Rib					
					Rib	PL	PRI-m				T12				PR	PLI-t	Rib					
						PL	PRI-m				L1				PR	PLI-m						
				Prone		PL	PRI-m				L2				PR	PLI-m		Prone				
						PL	PRI-m				L3				PR	PLI-m						
				Push		PL	PRI-m				L4				PR	PLI-m		Push				
						PL	PRI-m				L5				PR	PLI-m						
					+D	PI	IN				S1				PI	IN	+D					
				Hip	-D	AS	EX				S2				AS	EX	-D	Hip				
				Knee		P-L	ISU				S3				ISU	P-R		Knee				
				Foot			ISD				S4				ISD			Foot				
				Toes	LSL=		PL				Cx				PR	RSL=		Toes				

Posture Analysis		
Area	Findings	
FHP	+	-
Head Tilt	L	R
Head Rot	L	R
High Sh	L	R
Thor Tilt	L	R
Thor Trans	L	R
High Hip	L	R
Hip Rot	L	R
Foot Flare	L	R
Short Leg	L	R

_____

_____

_____

NP Exam 99201 / 99202 / 99203 EP Exam 99211 / 99212 / 99213

98940 98941 98942 98943 97124

PRN / Today / Tomorrow Monday Tuesday Wednesday Thursday

In 1 2 3 4 days / weeks 1 2 3 4 x / week for 1 2 3 4 weeks

Dr. Gina Kurtz signature: _____ Date: _____