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:_____
Job Description: _____
Emergency Contact: _____ Phone: _____ Relationship: _____
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

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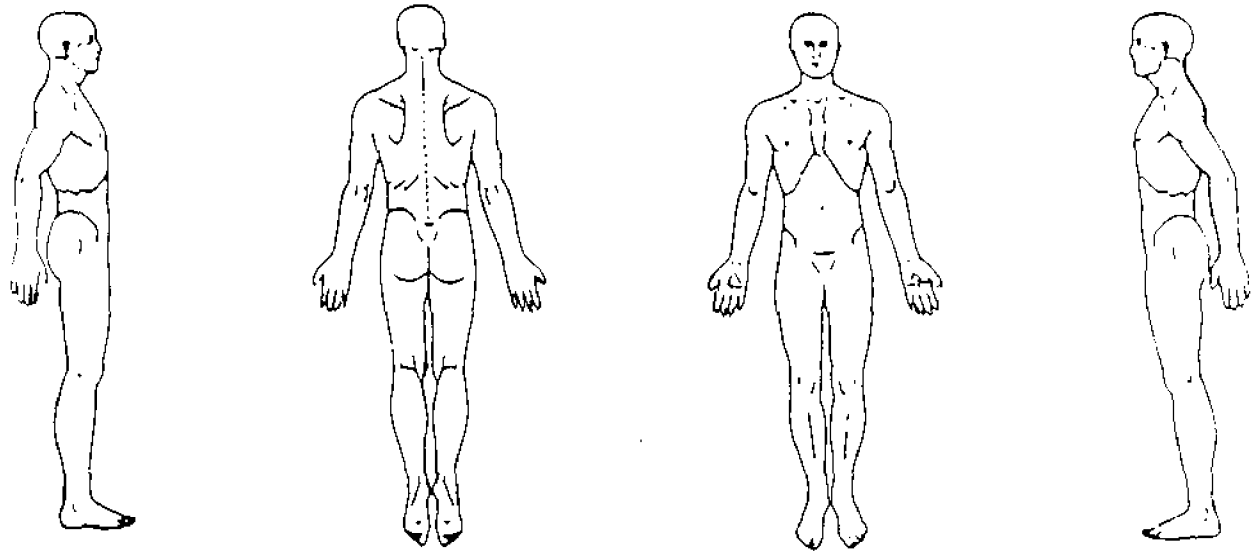
Current Problems

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 NUMBESS 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)

GENERAL	Past	Present
Allergy	☐	☐
Dizziness	☐	☐
Ear Problems	☐	☐
Fatigue	☐	☐
Colds/Sinus Infections	☐	☐
Headaches	☐	☐
Nervousness	☐	☐
Nose Bleeds	☐	☐
Numbness	☐	☐
Sore Throat	☐	☐
Sudden Weight Loss/Gain	☐	☐
Tonsillitis	☐	☐
GENITO-URINARY		
Frequent Urination	☐	☐
Inability to Control Urine	☐	☐
Kidney Infection or Stones	☐	☐
Painful Urination	☐	☐
Prostate Trouble	☐	☐
CARDIO-VASCULAR		
High Blood Pressure	☐	☐
Heart Condition	☐	☐
Swelling of Ankles	☐	☐

GASTROINTESTINAL	Past	Present
Constipation	☐	☐
Diarrhea	☐	☐
Gall Bladder Trouble	☐	☐
Intestinal Trouble	☐	☐
Nausea/Vomiting	☐	☐
Stomach Problems	☐	☐
RESPIRATORY		
Chest Pain	☐	☐
Chronic Cough	☐	☐
Difficulty Breathing	☐	☐
MUSCLE & JOINT		
Ankle Pain	☐	☐
Arm/Shoulder Pain	☐	☐
Elbow Pain	☐	☐
Foot Trouble/Pain	☐	☐
Knee Pain	☐	☐
Leg Pain	☐	☐
Neck Pain	☐	☐
Pain between Shoulders	☐	☐
Lower Back Pain	☐	☐
Rib Pain	☐	☐
Swollen Joints	☐	☐

DO YOU HAVE:	Yes	No
AIDS	☐	☐
Alcoholism	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
Mental Disorders	☐	☐
Nervous Breakdown	☐	☐
Polio	☐	☐
Rheumatic Fever	☐	☐
FOR WOMEN ONLY		
Hot Flashes	☐	☐
Irregular Cycle	☐	☐
Lumps in Breast	☐	☐
Painful Menstruation	☐	☐

HABITS

Coffee/Tea ______ Cups/Day

Tobacco _____ Pack(s) / _____

Alcohol _____ Drinks / _____

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: _____

Chiropractic Partners
Dr. Arturo Presas
5007 Southpark Drive Ste. 130
Durham, NC 27713
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Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Chiropractic Parnters or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

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 form (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._____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

4 Open areas divided by privacy curtains. Private treatment room available upon request.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness 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.

Female patients only: date of last menstrual cycle: _____
Is there any chance you are pregnant? ☐ Yes ☐ No

_____	_____	_____
Print Patient's Name	Signature (Patient or Guardian)	Date
_____	_____	_____
Witness (Print Name)	Signature	Date