The Khoury Centre For Health and Wellness

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PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Khoury Chiropractic Inc.'s *Notice of Privacy Practices for Protected Health Information.*

______________________________ ____________________
Patient Name Printed Date

____
Patient Signature

______________________________ ____________________
Witness Name Printed Date

____
Witness Signature

Our purpose at The Khoury Centre is to help as many people as possible achieve maximum health through chiropractic care, guidance, and education. Insurance regulations prohibit us from discounting or negotiating co-pays, co-insurances, deductibles, and other fees and charges. All fees for services are payable at the time they are rendered. We accept cash, checks, Visa and MasterCard. We do not send bills to our patients for personal balances. Verification of your benefits prior to your visit is your responsibility and is not a guarantee of payment, the patient is responsible for all bills incurred at this office.

We will bill your insurance company for their portion of the bill if we are in their provider network. All patients are expected to supply this office with any and all information necessary to file and bill your claims. In the event that claims are denied due to lack of insurance coverage for any reason, payment of any balance is the responsibility of the patient. Please note that insurance companies will only provide reimbursement for services which they deem medically necessary, and will not provide coverage for treatment that is considered wellness care, maintenance care, or for chronic conditions. Any checks sent to you from your insurance company for services rendered in this office must be brought into our office within 3 days.

It is understood and agreed that the amount paid the Doctor for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

Although unlikely, some patients may experience mild discomfort due to examination procedures. I hereby authorize the Doctor to examine and diagnose my condition as he or she deems appropriate.

Patient's Signature ________________________________ Date ____________________________

Confidential Patient Health Record

PERSONAL HISTORY

Name: ______________________________________

Address: ______________________________________

City: ______________________________________

State: __________ Zip/Postal Code: ______________

Home Phone Number: ______________________________

Which phone number do you prefer we use to contact you? ___________

Business Employer: ______________________________

Type of Work: ______________________________

Work Phone: ______________________________

Cell: ______________________________

Email Address: ______________________________

Would you like to receive email appointment reminders? Yes No

Would you like to receive our newsletters? Yes No

Date of Birth: ____________ Age: __ Sex: □ M □ F

Circle One: Single Married Widowed Divorced Separated

Race: __________________ Ethnicity: ________________________ Language: ______________________________

Current Employment: ________________________ Start date: ____________________

Height: ________________ Weight: _______________

Social Security Number: ___________________________

Drivers License Number: ___________________________

Referred To This Office By: ________________________

□ Personal Health Insurance Co.: ____________________

Insured Person's Name: ____________________________

Name Of Spouse (If applicable): ______________________

Name of Emergency Contact: ________________________

Phone Number of Emergency Contact: ________________

□ Health Card Number: ____________________________

Insured Person's Date of Birth: ______________________

CURRENT HEALTH CONDITION

Reason for Visit: ____

Other Doctors Seen For This Condition: □ Yes □ No If Yes Who? ___________________________________

Type of Treatment: ___________________________________ Results: ___________________________________

When Did This Condition Begin? _________________________ Has the Condition Occurred Before? □ Yes □ No

Is Condition: □ Job Related □ Auto Accident □ Home Injury □ Fall □ Other: ___________________________

Date of Accident: ______________________ Have You Made A Report Of Your Accident To Your Employer: □ Yes □ No

Are you being treated for low back pain? □ no □ yes -date you were diagnosed______________________

Do you have diabetes? □ no □ yes if yes, date diagnosed:______________ by: (Physician's name)____________________

Do you have high blood pressure? □ no □ yes -date you were diagnosed_______________ by:___________________

Name of Primary Care Physician (PCP):____

PCP Address: ____

Do You Wear a Shoe Lift? □ Yes □ No

Please list your current medications, date started, type, strength, dosage, duration, and prescribing doctor. Use the back of this page if necessary

____

____

Have you had any tests in the last year (lab, x-ray, MRI etc) please list test and result:

____

____

Do you smoke? □ no □ yes- how much/often ____

Do you have allergies?: □ no □ yes- to what? ________________________ what is your reaction?__________________

Do you drink coffee: □ no □ yes how much:__________ Do you drink: alcohol: □ no □ yes how much:______________

Do you use drugs: none recreationally addicted

Do you exercise: never daily weekly walks run swim

PAST HEALTH HISTORY

Patient Name:____

Previous Chiropractic Care: ◻ None ◻ Doctor's Name & Approximate Date of Last Visit:__________________________

Major Surgery/Operations: please list surgery, date, and result:____

____

Major Accidents Or Falls (please note when): ____

____

Hospitalization (other than above please list date, reason, and hospital):

____

____

Family history: please list family member, condition:

Relationship	Disease(s) or condition(s)	Deceased ?	Cause of death
________________	________________________	◻ Yes ◻ No	____________________
________________	________________________	◻ Yes ◻ No	____________________
________________	________________________	◻ Yes ◻ No	____________________
________________	________________________	◻ Yes ◻ No	____________________

Confidential Patient Health Record

"GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTION TEST"

Instructions: Please check the correct response.

Historical Information

- Have you ever been diagnosed or told you have any of the following?
  1. High Blood Pressure (hypertension) ◻ Yes ◻ No
  2. Hardening of the arteries (arteriosclerosis) ◻ Yes ◻ No
  3. Diabetes ◻ Yes ◻ No
  4. Heart or blood vessel diseases ◻ Yes ◻ No
  5. Bone spurs on the neck bones (cervical spondylosis) ◻ Yes ◻ No
  6. Whiplash injury (flexion-extension injury) (cervical spine) ◻ Yes ◻ No
  7. Have any of your relatives suffered a stroke? ◻ Yes ◻ No
  8. Were you ever a smoker? If yes, from __________ to _______________ ◻ Yes ◻ No
  9. Do you take any medications on a regular basis? ◻ Yes ◻ No
     - You will be asked to list these on page 3
  10. (Women Only) Have you ever taken oral Contraceptives? ◻ Yes ◻ No
      - If yes, from _____________________ to ______________________
- Have you ever had any of the following, even short, temporary attacks, in the last year?
  1. Blurred Vision ◻ Yes ◻ No
  2. Double Vision ◻ Yes ◻ No
  3. Diminished or partial loss of vision in one or both eyes? ◻ Yes ◻ No
  4. Complete loss of vision in one or both eyes? ◻ Yes ◻ No
  5. Ringing, buzzing or any noise in the ear(s)? ◻ Yes ◻ No
  6. Hearing loss in one or both ears? ◻ Yes ◻ No
  7. Slurred speech or other speech problems? ◻ Yes ◻ No
  8. Difficulty swallowing? ◻ Yes ◻ No
  9. Dizziness? ◻ Yes ◻ No
  10. Temporary lack of understanding? ◻ Yes ◻ No
  11. Loss on consciousness, even momentary blackouts? ◻ Yes ◻ No
  12. Numbness or loss of sensation in the face, fingers, hand, arms, legs, or any other parts of your body? ◻ Yes ◻ No
  13. Any other abnormal sensations in any part of your body? ◻ Yes ◻ No
  14. Weakness, clumsiness or loss of strength in the face, finger, hands, arms, or legs? ◻ Yes ◻ No
  15. Sudden collapse without loss of consciousness? ◻ Yes ◻ No

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Below is a list of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect you overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD and write in approximately when:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

Have you been tested HIV Positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL CODE
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

NERVOUS SYSTEM CODE
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Headaches

GASTRO-INTESTINAL CODE
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

GENITO-URINARY CODE
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODES
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ ______________________________

____

FEMALES ONLY

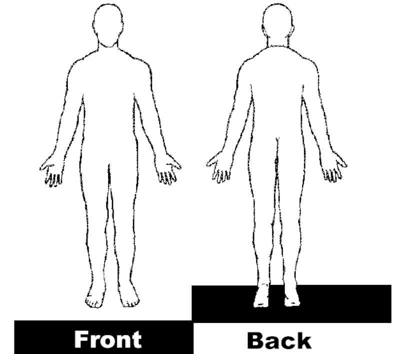
When was your last period?

____

Are you Pregnant?

☐ Yes ☐ No

GENERAL CODE
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever



Please outline on the diagram the area of your discomfort

The above health history and information is complete and accurate. If a new symptom or condition arises during my treatment I will notify the doctor as soon as possible.

____

Patient Name Printed

______________________________ ______________________________

Patient Signature Date