

**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 The Khoury Centre For Health & Wellness' *Notice of Privacy Practices for Protected Health Information*.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

**Confidential Patient Health Record**

**PERSONAL HISTORY**

Name: \_\_\_\_\_ Business Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ Type of Work: \_\_\_\_\_  
City: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
State: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_ Sex:  M  F Circle One: Single Married Widowed Divorced Separated  
Social Security Number: \_\_\_\_\_ Name Of Spouse (If applicable): \_\_\_\_\_  
Drivers License Number: \_\_\_\_\_ Name of Emergency Contact: \_\_\_\_\_  
Referred To This Office By: \_\_\_\_\_ Phone Number of Emergency Contact: \_\_\_\_\_

Who is Responsible For Your Bill, You and  Spouse  Workers' Comp  Auto Insurance  Medicare  
 Personal Health Insurance Co.: \_\_\_\_\_  Health Card Number: \_\_\_\_\_  
Insured Person's Name: \_\_\_\_\_ Insured Person's Date of Birth: \_\_\_\_\_

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**CURRENT HEALTH CONDITION**

Reason for Visit: \_\_\_\_\_  
Name of Primary Care Physician (PCP): \_\_\_\_\_  
PCP Address: \_\_\_\_\_  
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: \_\_\_\_\_ Time of Accident: \_\_\_\_\_  
Have You Made A Report Of Your Accident To Your Employer:  Yes  No  
Drugs You Take Now:  Nerve Pills  Pain Killers/Muscle Relaxers  Blood Pressure Medicine  Insulin  Other  
\_\_\_\_\_  
Do You Wear a Shoe Lift?  Yes  No  
Do You Suffer From Any Other Condition Other Than That Which You Are Now Consulting Us? \_\_\_\_\_  
\_\_\_\_\_

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**PAST HEALTH HISTORY**

Please Check and Describe:  
Major Surgery/Operations:  Appendectomy  Tonsillectomy  Gall Bladder  Hernia  Back Surgery  Broken Bones  
 Other \_\_\_\_\_  
Major Accidents Or Falls: \_\_\_\_\_  
Hospitalization (Other Than Above): \_\_\_\_\_  
Previous Chiropractic Care:  None  Doctor's Name & Approximate Date of Last Visit: \_\_\_\_\_

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 your overall course of care.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Mumps         | <input type="checkbox"/> Influenza        |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox     | <input type="checkbox"/> Pleurisy         |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Arthritis        |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Epilepsy         |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago          |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Thyroid       | <input type="checkbox"/> 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

**GENERAL CODE**

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- 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

**Please outline on the diagram the area of your discomfort**

**FAMILY HISTORY**

The following members have a same or similar problems as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

**“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
      - If yes, what? (Coumadin, Heparin, Aspirin, Anti-hypertensive medicine, etc.)
    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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Our purpose at Khoury Chiropractic is to help as many people as possible achieve maximum health through chiropractic care, guidance, and education.

It is our policy that payments for all services are due at the time they are rendered and are not billed periodically to patients. Billing for patients’ personal balances increases offices expenses resulting in higher costs of services. We accept cash, personal checks, and most credit cards.

As a courtesy to you we will bill your insurance company for their portion of the bill. All patients are expected to supply this office, in a timely manner, with any and all information necessary to file and bill your claims. 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 to 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.

If you have a treatment schedule for multiple appointments in one week and do not wish to pay each time, you may pre-pay at the beginning of the week. By doing this it will save you time at each appointment.

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 \_\_\_\_\_