PATIENT HISTORY

Date of Birth ________ Age ________ Social Security # ________

Last ________ First ________ Middle Initial ________

Address ________ City ________ ST ________ Zip ________

Phone (H) ________ (W) ________ (C) ________

Email ________ May we send you our online newsletter? ☐yes ☐no

Your Occupation ________ Employer ________

Spouse's Name ________ Spouse DOB ________ Spouse SSN: ________

Have you been to another doctor for this problem? ☐yes ☐no Who/Where? ________

Who may we thank for referring you to this office? ________

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: ________

Date when symptom first appeared ________ Did it begin: ☐Gradual ☐Sudden ☐Progressive over time

What makes the symptoms increase? ________ What relieves the symptoms? ________

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb Does the Pain Radiate into your: ☐Arm ☐Leg ☐Does not radiate

Do you have Numbness or Tingling? ☐yes ☐no How often do you experience these symptoms? ☐100% ☐75% ☐50% ☐25% ☐10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) ________

Please list all previous treatments for this condition (give doctor's name and dates if possible) ________

Do you have any family members who suffer from the same complaint? If so, who? ________

SECONDARY COMPLAINT: ________

Date when symptom first appeared ________ Did it begin: ☐Gradual ☐Sudden ☐Progressive over time

What makes the symptoms increase? ________ What relieves the symptoms? ________

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb Does the Pain Radiate into your: ☐Arm ☐Leg ☐Does not radiate

Do you have Numbness or Tingling? ☐yes ☐no How often do you experience these symptoms? ☐100% ☐75% ☐50% ☐25% ☐10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) ________

Please list all previous treatments for this condition (give doctor's name and dates if possible) ________

Do you smoke? ☐yes ☐no If yes, how many packs per week? ________

Have you ever smoked in the past? ☐yes ☐no If yes, when did you quit? ________

Do you take birth control? ☐yes ☐no Have you ever taken birth control in the past? ☐yes ☐no

Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? ________

Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? ________

Do you exercise? ☐yes ☐no If yes, how many times per week and what type? ________

Do you have a high stress level? ☐yes ☐no If yes, list reasons: ________

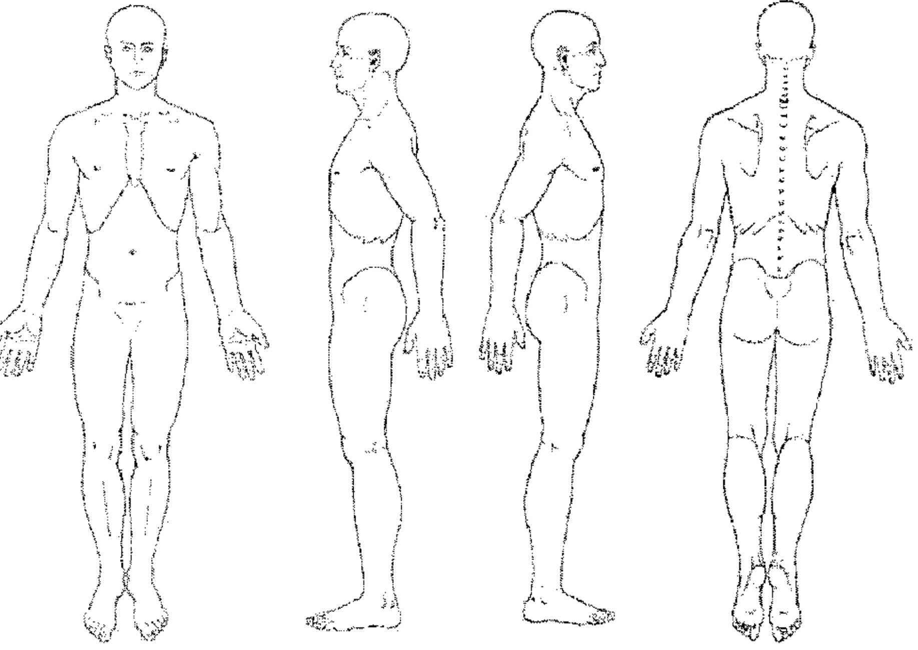
Please list any medications or vitamins you are currently taking:

____

PATIENT SIGNATURE ________ DATE ________

Please mark off the areas of your complaint on the diagram above with the following indicators:

PPP = pain
NNN = numbness
TTT= tingling
BBB= burning
CCC= cramping
XXX = other



Please list all surgeries, injuries, accidents, falls, etc: ______________________

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____

____

____

Please check if you have had any of the following:

☐ AIDS/HIV	☐ Alcoholism	☐ Anemia	☐ Allergy Shots	☐ Anorexia
☐ Anorexia	☐ Arthritis	☐ Asthma	☐ Bleeding Disorders	☐ Breast Lump
☐ Bronchitis	☐ Bulimia	☐ Cancer	☐ Cataracts	☐ Chemical Dependency
☐ Chicken Pox	☐ Diabetes	☐ Disc Degeneration	☐ Emphysema	☐ Epilepsy
☐ Epilepsy	☐ Glaucoma	☐ Goiter	☐ Gonorrhea	☐ Gout
☐ Heart Attack	☐ Heart Disease	☐ Hepatitis	☐ Hernia	☐ Herpes
☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Liver Disease	☐ Measles
☐ Migraine	☐ Miscarriage	☐ Mononucleosis	☐ MS	☐ Mumps
☐ Osteoporosis	☐ Pacemaker	☐ Parkinson's Disease	☐ Pinched Nerve	☐ Pneumonia
☐ Polio	☐ Prostate Problem	☐ Prosthesis	☐ Psychiatric Care	☐ Stroke
☐ Rheumatic Fever	☐ Scarlet Fever	☐ Suicide Attempt	☐ Thyroid Problems	☐ Tonsillitis
☐ Tuberculosis	☐ Tumors/Growths	☐ Typhoid Fever	☐ Ulcers	☐ Vascular Disease
☐ Vaginal Infections	☐ Venereal Disease	☐ Whooping Cough	☐ Rheumatoid Arthritis	
☐ Other:				

PATIENT SIGNATURE ______________________ DATE ________

Kara Rosenstrauch, D.C.
1864 Woodmoor Dr. #201
Monument, CO 80132

Consent Form for Chiropractic

Chiropractic focuses on the nervous system and the spinal cord. During chiropractic treatment, the doctor will use his/her hands or a mechanical device in order to align your spine to correct interference to the nervous system and improve the body's ability to control and coordinate many functions. You may feel a "click " or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joint, or injury to intervertebral discs, nerves or spinal cord. Stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment.

The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures.

I, ______________________________, understand the hazards and potential dangers involved in treatment by means of chiropractic. I believe that this treatment is in my best interest and I understand that no guarantee of results has been made.
I understand that it usually requires a series of chiropractic treatments to significantly change a condition and receive benefit.

Laser Therapy: The MR4 Super Pulsed Laser has been designated "unproven" by the Colorado State Board of Chiropractic Examiners. By signing below you are stating that permission is granted by to proceed with Laser Therapy.

My signature indicates that I have read and fully understand the above information regarding the consent to this procedure. My signature below authorizes this procedure should I require it for my condition.

Patient Signature (Legal Guardian) Printed Name Date

Practitioner Statement: The patient (or patient's representative) and I have discussed this procedure, the risks and alternatives to this procedure. To the best of my knowledge, the patient (or patient's representative) understands this procedure and consents to it.

Practitioner Signature Practitioner Printed Name Date

Kara Rosenstrauch, D.C.
1864 Woodmoor Dr. #201
Monument, CO 80132

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

The Practice:
1) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to you PHI.

2) May be required by Colorado law to maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

3) Is required to abide be the terms of the Privacy Notice.

4) Reserves the right to change the terms of the Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

5) Will distribute any revised Privacy Notice to you prior to implementation.

6) Will not retaliate against you for filing a complaint.

This Notice is in effect as of 03/14/03.

I, , have received a copy of Kara Rosenstrauch,s Notice of Privacy Practices.

____
Signature of Patient of Guardian Date

Patient's acknowledgement of this Notice could not be obtained because:

Patient refused to sign
Communication barrier prohibited obtaining acknowledgement
Emergency Circumstances
Other:

____
Signature of Practice Staff Date