PATIENT HISTORY

Klucharich Whole Body Healing 843– 664 - 0900

Last _____ First _____ Middle Initial _____

Date of Birth _____ Age _____ Social Security # _____

Address _____ City _____ ST_____ Zip _____

Phone (H) _____ (W) _____ (C) _____ Email _____

Emergency Contact _____ Phone # _____

Your Occupation _____ Employer _____ Is your symptoms due to an auto accident Y N

Have you ever seen a Chiropractor before? Y N Who/Where? _____

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 ☐Shoot 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 minor, 10 being extreme) _____

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

_____

SECOND 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 minor, 10 being extreme) _____

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

_____

THIRD 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 minor, 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? ____ Do you have a high stress level? ☐yes ☐no

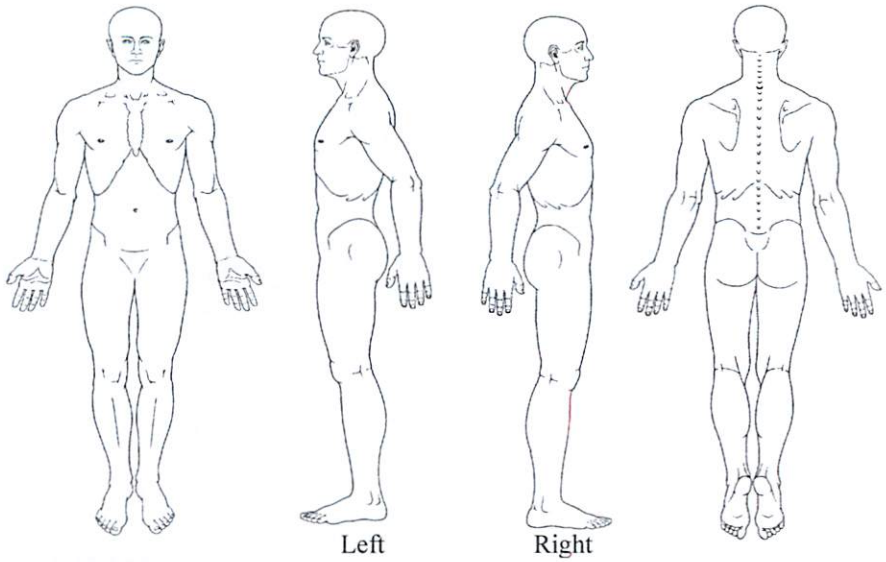
Do you exercise? ☐yes ☐no If yes, how many times per week ? _____ Please list any medications or vitamins you are currently taking:

_____

PATIENT SIGNATURE _____ DATE: _____ Dr. Signature: _____

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 check if you have had any of the following:

☐ Neck Pain	☐ Shoulder Pain	☐ Pain bwtn Shld Baldes	☐ Mild or ☐ Moderate Headaches	☐ Migraines
☐ Arm Pain	☐ Low Back Pain	☐ Buttocks Pain	☐ Occasional or ☐ Freq. Headaches	☐ Leg Pain

Please check if you have had any of the following:

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

Please list all surgeries: _____

_____

_____

_____

For Women Only

Are You Pregnant ? ☐ Yes ☐ No Are You Taking Birth Control Pills ? ☐ Yes ☐ No
At this time to the best of my knowledge I am not pregnant and consent to X- Rays if necessary _____
Patient Signature

PATIENT SIGNATURE _____ **DATE:** _____ **Dr. Signature:** _____

Activities of Daily Living Assessment

Please rate the PAIN LEVEL below with the activity listed.
MILD pain is 1, 2, 3 **MODERATE** pain is 4, 5, 6 **SEVERE** pain is 7, 8, 9, 10

Please use the letter from the key below.
C= Neck, T= Mid back, L= Low back, S= Shoulder, E= Elbow, W= Wrist
H= Hips, K= Knees, A= Ankles Designate **RT** or **LT**

Put the pain level with a letter from the key next to the activity you are having pain with.
Example: **5C** Washing hair

Self Care

____ Bathing
____ Showering
____ Washing hair
____ Drying hair
____ Combing hair
____ Washing feet
____ Brushing teeth
____ Making bed
____ Putting on shirt
____ Putting on shoes
____ Getting out bed
____ Putting on pants
____ Preparing meals
____ Eating
____ Cleaning dishes
____ Taking out trash
____ Doing laundry
____ Going to toilet

Physical Activities

____ Standing
____ Sitting
____ Reclining
____ Walking
____ Standing for long periods
____ Stooping
____ Squatting
____ Kneeling
____ Reaching
____ Sitting for long periods
____Bending forward
____ Bending back
____ Bending left
____ Bending right
____ Walking for long periods
____ Twisting Left
____ Twisting right
____ Leaning forward
____ Leaning back
____ Kneeling for long periods
____ Leaning left
____ Leaning right

Functional Activities

____ Carrying small objects
____ Carrying large objects
____ Carrying brief case
____ Carrying large purse
____Lifting weight off floor
____Lifting weight off table
____ Climbing stairs
____ Climbing inclines
____Pushing things while seated
____Pushing things while standing
____Pulling things while seated
____Pulling things while standing
____Exercising upper body
____Exercising lower body
____ Exercising arms
____ Exercising legs

Traveling

____ Driving a motor vehicle
____ Driving for long periods
____ Riding as a passenger in a motor vehicle
____ Riding as a passenger for long periods

Hand functions

____ Grasping ____ Holding ____Pinching ____Twisting ____ Turning

Rest / Relaxation ____Ability to Sleep Comments_____

Other Activities not listed above that you have difficulty doing? (Record data same way as above)

Pain # Activity

____ - _____

____ - _____

_____ Patient Signature

_____ Date

HEALTH CARE AUTHORIZATION FORM

SP 3

Patient's Name _____ Patients SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **KLUCHARICH WHOLE BODY HEALING** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- ❑ I give permission to **KLUCHARICH WHOLE BODY HEALING** to use my personal health information for reminder telephone calls, or mail correspondence.
- ❑ I give permission to **KLUCHARICH WHOLE BODY HEALING** to treat me in this office where occasionally my name may be visible to other patients. Although unlikely, there is potential for others to see your name listed on a chart or document.
- ❑ I give **KLUCHARICH WHOLE BODY HEALING** permission to treat me in a therapy room where other patients are also being treated. Adjustments will be performing in a private room. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private; the doctor will provide a room for these conversations.

EXPIRATION

The Authorization shall expire on the following date: _____ ← This date to be filled in by KWBH employee

_____ _____

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that if I request to see the *Notice of Information Practices* that provides a more complete description of information uses and disclosures, it will be made available to me. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

_____ _____

Patient Signature Date

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

The written notice must contain the following information:

1. Your name, Social Security number and date of birth;
2. A clear statement of your intent to revoke this AUTHORIZATION;
3. The date of your request; and your signature.

The revocation is not effective until it is received by the Privacy Official.