Thorpe Chiropractic Office

Dr. David A. Thorpe
Dr. Kent R. Thorpe

Patient Name: ____ Date: ____________

Address________________________________City________________ State __________ Zip Code ___________

H. Phone ___________________________W. Phone________________ Cell Phone _________________________

Email Address: ____________________________Cell Phone Carrier______________________________________

Sex M F Marital Status M S D W Date of Birth______________ Age___________

Social Security#______-____-_________Occupation__________________________Employer_________________________

Referred by: ________________________________Emergency Contact:____

Relationship to Emergency contact______________________________Phone_______________________________________

Have you ever received Chiropractic Care? Yes No If yes, when? _________________________________

Name of most recent Chiropractor: ____

Language:__English__Spanish__Indian__Japanese__Chinese__Korean__French__German__Russian__Other

Do you authorize text reminders? __Yes__No Do you authorize e-mails?__Yes__No

Contact Preference __Home__Work__Cell__E-mail__Post mail

Ethnicity__Caucasian (non-Hispanic)__African American (non- Hispanic)__Native American/Alaskan__Hispanic/Latino
__Asian__Middle Eastern__Pacific Islander__Other___________________

Insurance Information

We will make a copy of your insurance card/s. However, please complete the following information.

Are you the policy holder? Y N If no, who is policy holder: Spouse Parent Employer Other

Policy Holder's Name:
First Name: ___________________________________ M.I. __________ Last Name: _________________________

Policy Holder's Date of Birth: ______________________ Policy Holder's SS#: ________________________

Insurance ID# :___________________________________ Insurance Company :____________________________
Policy Holder's Employer: _____________________________ Claim#: (auto accident) _________________________

Do you have secondary insurance coverage? Y N If yes, please complete the following:

Policy Holder's Name:
First Name: ______________________________________ M.I. ___________ Last Name: _________________________

Policy Holder's Date of Birth: ____________________ Policy Holder's SS#: _________________________________
Policy Holder's Employer: ____
Insurance ID# :___________________________________ Insurance Company :____________________________

7211 East Genesee Street
Fayetteville, NY 13066
Phone: (315) 637-0706
Fax: (315) 637-0708
www.thorpe-dc.com

Patient Name: ____ **Date:** __________

1. Reasons for seeking chiropractic care:

Primary reason:
____

Secondary reason:
____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):
____
____
____

3. Past Health History:

A. Please indicate if you have a history of any of the following:

□ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
□ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
□ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other __________
□ None of the above

B. Previous Injury or Trauma:
____

Have you ever broken any bones? Which?
____

C. Allergies: ____

D. Medications:

Medication Reason for taking
____
____
____
____

E. Surgeries:

Date Type of Surgery
____
____
____
____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery Outcome
____
____
____
____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____________ □ None of the above

Deaths in immediate family: ____

Cause of parents or siblings death Age at death
____
____
____

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Patient Name: ____ **Date:** ___________

Social and Occupational History:

A. **Job description:**
____

B. **Work schedule:**
____

C. **Recreational activities:**
____

D. **Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):**

____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other ___________ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other __________ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Other ______________ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes □ Other _______________ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis □ Other ____________________ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other ________ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia □ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use □ Other ______________ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _________ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other ____________________ □ None of the above

Patient Name: ____ **Date:** ____________

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other ____________ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? ___________________________

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Dr. David A. Thorpe, DC, DACBOH, CME of Thorpe Chiropractic Office for services performed.

Patient or Guardian Signature ________________________________
Date_________________________

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

____________________________________ ________________________
Signature of Patient of Representative Date

____
Printed Name

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Patient Name: ____ **Date:** ___________

Give a brief detailed description of the problem you are currently experiencing:

____

____

When did the problem start? ______________ Is it getting worse? □ Yes □ No

____

What seemed to be the initial cause:

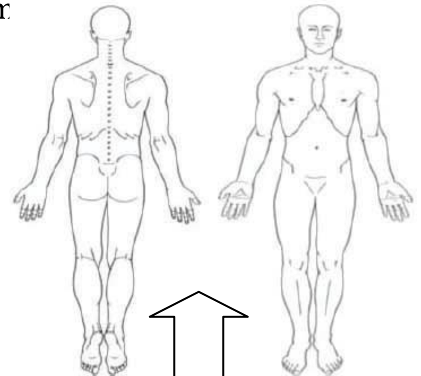
____

How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

How are your symptom

- Getting Better
- Not Changing
- Getting worse



Indicate where you have pain or other symptoms

How bad are your symptoms at their:		None										Unbearable
	a. worst	0	1	2	3	4	5	6	7	8	9	10
	b. best	0	1	2	3	4	5	6	7	8	9	10

What describes the current nature of your symptoms?

- Sharp
- Dull ache
- Numb
- Shooting
- Burning
- Tingling

Past health history

Have you…	Yes	No	If yes, include date & provider seen
...been hospitalized in the last 5 years?	□	□	______________________________
...been diagnosed with Diabetes	□	□	______________________________

Type I____or Type II_____

Vitals

Height ________ Weight ________ Blood Pressure ________

Do you smoke? □Never □Former Smoker □Current/Every Day Smoker □Current Some Day Smoker

Medications

What medications are you currently taking? Include vitamins, herbs, minerals…

List Date Started, Brand Name, Generic Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by

Please be as specific as possible

____

____

____

____

____

Do you have allergies? □Food □Environmental □Medication

List Type of Allergy and Reaction

____

____

____

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