COOK CHIROPRACTIC

Dr. Jeffrey K. Cook - Dr. Randal G. Troutman – Dr. Vincent D. Brown

1715 S MAIN ST. KANNAPOLIS, NC 28081
704-938-7111

For Office Use Only
Date: _____
Acct #: _____
Patient Height _____
Patient Weight _____
B/P _____
Pulse _____

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Age:** _____ **Male:** ____ **Female:** _____

SS#: _____ **Phone#** _____

Marital Status: _____ **Spouse's name:** _____

Email Address: _____

Number of Children: _____ Referred By: _____

Race (circle only 1) American Indian - Alaska Native - Asian - White
Black or African American - Native Hawaiian
Other Pacific Islander - Declined to State

Ethnicity (circle only 1) Declined to State - Hispanic or Latino - Not Hispanic or Latino

Please List Any Other Doctors you have consulted for this condition: _____

Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Spouse Worker's Comp
Auto Insur. Medicare Medicaid Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Primary Care Physician _____

Are your present problems due to an injury? ❑Yes ❑No Enter the date of the injury: _____

Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: _____

Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other: _____

Do you have any current work restrictions due to this condition?

Off work: ❑Yes ❑No ❑Previously From: _____ To: _____

Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) _____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No

Employer Data

Name:_____

Your Occupation:_____Your Job Description:_____

Spouse Data

Name: _____Phone #:_____

Date of Birth:_____Employer: _____

HABITS

❑Current Every Day Smoker ❑Current Some Day Smoker

❑Former Smoker ❑Never Smoker

EXERCISE

❑None

❑Moderate

❑Daily

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other	
Mother	❑	❑	❑	❑	_____
Father	❑	❑	❑	❑	_____
Sibling(s)	❑	❑	❑	❑	_____

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No

If Yes, please indicate the following:

Medication: _____ Medication: _____

Medication: _____ Medication: _____

Medication:_____ Medication: _____

Do you have allergies to medication? ❑Yes ❑No

If Yes, please indicate the following medications:

_____ _____

_____ _____

_____ _____

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

DATE		DATE		DATE	
_____	Back Operation	_____	Hernia	_____	Gall
Bladder_____	Female Organs	_____	Thyroid	_____	Stomach

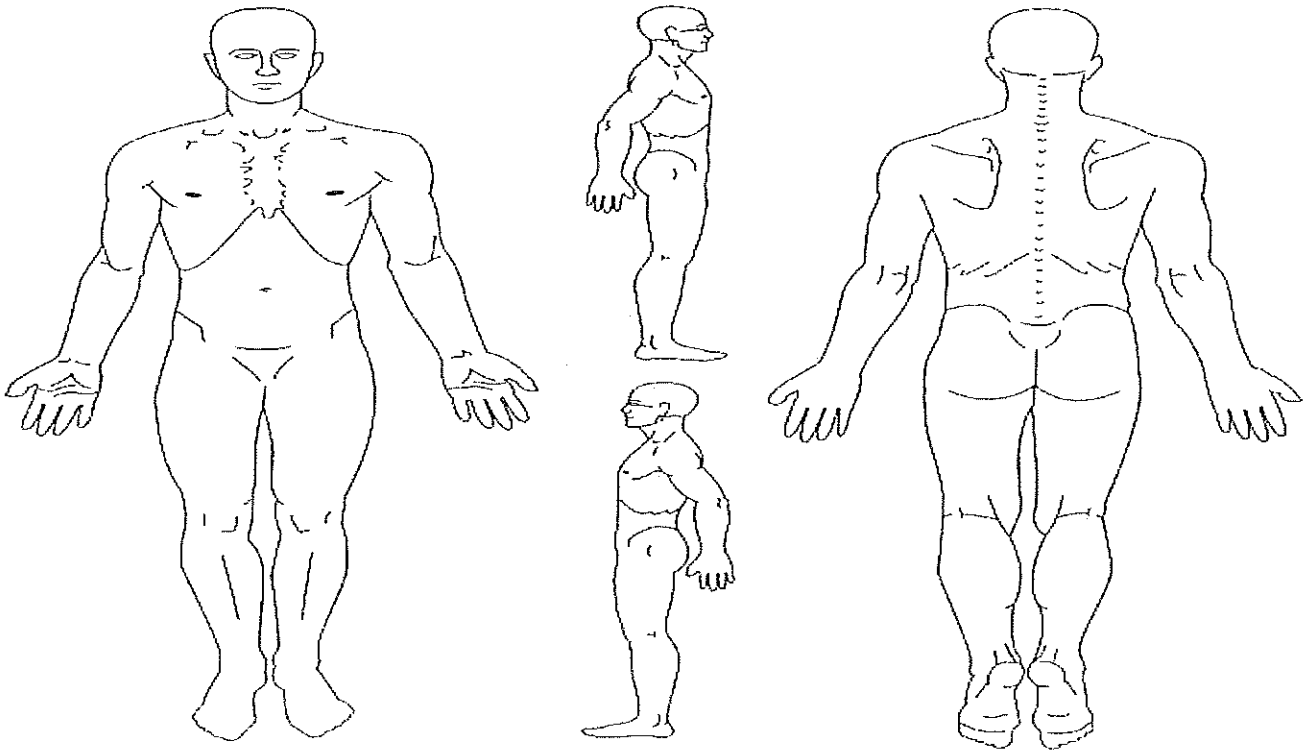
Other _____

List symptoms experiencing	Choose the severity level associated with each symptom
_____	□(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Severe
_____	□(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Severe
_____	□(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Severe
_____	□(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Severe

PATIENT NAME:_____DATE:_____

Are you pregnant? Yes_____ No _____N/A_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:
N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

_____

_____

How bad are your symptoms at their **a. worst 1 2 3 4 5 6 7 8 9 10**
b. best 1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities?

_____ ☐ **No Effect** ☐ **Mild** Painful (Can do) ☐ **Mod** Painful (limited) ☐ **Sev** 0 Performance
_____ ☐ **No Effect** ☐ **Mild** Painful (Can do) ☐ **Mod** Painful (limited) ☐ **Sev** 0 Performance
_____ ☐ **No Effect** ☐ **Mild** Painful (Can do) ☐ **Mod** Painful (limited) ☐ **Sev** 0 Performance

How often do you experience your symptoms?

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

What describes the nature of your symptoms?

Sharp	Dull ache	Numb	Shooting
Burning	Tingling	Stabbing	Other _____

Doctor's Signature _____

Emergency Contact _____

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (____) _____-_____ **Cell Phone (____)** _____-_____

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review Cook Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____ Date_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____
Date_____

PLEASE LIST PERSON/PERSON'S THAT MAY HAVE ACCESS TO YOUR MEDICAL RECORDS:
NAME:_____PHONE:_____
NAME:_____PHONE:_____
NAME:_____PHONE:_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office.
I authorize the doctor to release all my information necessary to communicate with personal physicians and other healthcare providers and payers to secure the payment of benefits, I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.
The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want to know your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

PATIENT SIGNATURE: _____DATE: _____

WITNESS: _____DATE: _____