



**Hooper-Thurston
Elite Chiropractic**
A Member of Elite Chiropractic Centers

**DR. MARK HOOPER
DR. MARK THURSTON
DR. BRIAN HOOPER**

Paciente _____
(Primer) (Segundo) (Apellido)

Dirección _____

Cuidad _____ Estado _____ Zip _____

Tel. Primario _____ # Tel. secundario _____

Fecha de Nacimiento _____ Edad _____
(Mes) (Día) (Año)

Seguro Social _____

Soltero/a () Casado/a () Nombre de esposo/a _____

Empleador del paciente _____

Tel. del trabajo _____

Empleador de esposo/a _____

Tel. del trabajo _____

E-mail _____

Pasatiempos _____

Queja _____

La queja esta relacionada con un accidente? Si () No ()

Fecha del accidente _____ Hora _____ a.m./p.m.

Relacionado con el trabajo () Relaciono con un auto () Otro ()

**Los pagos se harán al tiempo de su visita,
al menos que otros arreglos se hagan hecho por adelantado**

Fecha

Firma Del Paciente



Historial del Paciente

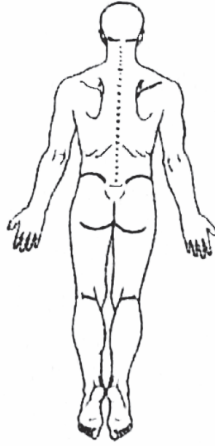
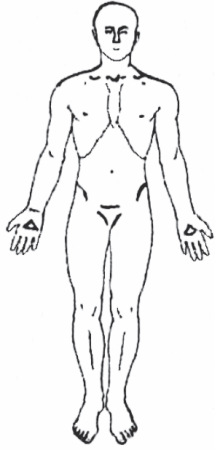
Patient History

Nombre _____ Fecha _____
Patient Name Date

A recibido Usted cuidado Quiropráctico? Si o No Si, sí Cuando?
Have you ever received Chiropractic Care? Yes or No If yes, when?

Simtomas actuales: _____
Current Symptoms

1. Ubicación (Donde le duele?) Indique la area(s) en la ilustración
1. Location (Where does it hurt?) Circle the area(s) on the illustration



2. Simtomas

- Entumecido
Numbness
- Hormigueo
Tingling
- Rigidez
Stiffness
- Dolor Apagado
Dull
- Adolorido
Aching
- Calambres
Cramps
- Molesto
Nagging
- Agudo
Sharp
- Ardiente
Burning
- Pinchazo
Shooting
- Palpitante
Throbbing
- Punzante
Stabbing
- Otro
Other

3. Intesidad
Intensity
 O--O--O--O--O--O--O--O--O--O
 1 2 3 4 5 6 7 8 9 10
 Cómo se siente? Ausente Incómodo Agonizante
What does it feel like? Absent Uncomfortable Agonizing

4. Duración y Frecuencia Cuando inicio? _____ Con qué frecuencia lo sientes? Constante Viene y va
Duration & Timing When did it start? How often do you feel it? Constant Comes and goes

5. Radiación (Afecta a otras area de su cuerpo? A que otra area de su cuerpo irradiar el dolor, viaja o dispara?) _____
Radiation (Does it affect other areas of your body? and what areas does the pain radiate, shoot or travel?)

6. factores agravan o lo alivian (Que lo hace mejor o peor, como la hora del día, los movimientos, ciertas actividades, etc.)
Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

7. Intervenciones Anteriores (Qué ha hecho para aliviar los síntomas?)
Prior interventions (What have you done to relieve the symptoms?)

- | | | |
|---|---|---|
| <input type="checkbox"/> Prescripción Médica
<i>Prescription medication</i> | <input type="checkbox"/> Cirugía
<i>Surgery</i> | <input type="checkbox"/> Hielo
<i>Ice</i> |
| <input type="checkbox"/> Medicamentos de Venta Libre
<i>Over-the-counter drugs</i> | <input type="checkbox"/> Acupuntura
<i>Acupuncture</i> | <input type="checkbox"/> Color
<i>Heat</i> |
| <input type="checkbox"/> Remedios Homeopáticos
<i>Homeopathic remedies</i> | <input type="checkbox"/> Quiropráctica
<i>Chiropractic</i> | <input type="checkbox"/> Otro
<i>Other</i> |
| <input type="checkbox"/> Terapia Física
<i>Physical Therapy</i> | <input type="checkbox"/> Masaje
<i>Massage</i> | |

8. Qué más debería saber el médico sobre su condición actual? _____
What else should the doctor know about your current condition?

9. En la ACTUALIDAD experimenta ALGUNO de los siguientes?
Do you CURRENTLY experience ANY of the following?

- | | |
|---|--|
| <input type="checkbox"/> Problemas Urinarios
<i>Urinary Problems</i> | <input type="checkbox"/> problemas intestinales
<i>Bowel Problems</i> |
| <input type="checkbox"/> Salpullido en la Piel
<i>Skin Rashes</i> | <input type="checkbox"/> Problema de Coagulación de Sangre
<i>Blood Clotting Issues</i> |
| <input type="checkbox"/> Desmayos
<i>Fainting</i> | <input type="checkbox"/> Calambres Musculares
<i>Muscle Cramping</i> |
| <input type="checkbox"/> Migrañas
<i>Migraines</i> | <input type="checkbox"/> Problemas del Riñón
<i>Kidney Problems</i> |
| <input type="checkbox"/> Problemas de Visícula
<i>Bladder Problems</i> | <input type="checkbox"/> Perdida de Peso
<i>Weight Loss</i> |
| <input type="checkbox"/> Mareos o Vertigo
<i>Dizziness/Vertigo</i> | <input type="checkbox"/> Dolor de Pecho
<i>Chest Pain</i> |

Fecha del último examen físico: _____
Date of last Physical Examination

- | | | |
|--|---|---|
| <input type="checkbox"/> Sudor Nocturno
<i>Night Sweats</i> | <input type="checkbox"/> Fiebre
<i>Fever</i> | <input type="checkbox"/> Perdida de Apetito Sexual
<i>Diminished Sex Drive</i> |
| <input type="checkbox"/> Sensibilidad al Frio
<i>Sensitivity to Cold</i> | <input type="checkbox"/> Colesterol Alto
<i>High Cholesterol</i> | <input type="checkbox"/> Problemas Estomacales
<i>Stomach Problems</i> |
| <input type="checkbox"/> Depresión
<i>Depression</i> | <input type="checkbox"/> Fatiga Fácilmente
<i>Fatigue Easily</i> | <input type="checkbox"/> Irregularidad menstrual
<i>Menstrual Irregularities</i> |
| <input type="checkbox"/> Toz Crónica o Frecuente
<i>Chronic or Frequent Cough</i> | <input type="checkbox"/> Ansiedad
<i>Anxiety</i> | <input type="checkbox"/> Problemas de Próstata
<i>Prostate Problems</i> |
| <input type="checkbox"/> Otro
<i>Other</i> | <input type="checkbox"/> Infección Recurrente
<i>Recurrent Infection</i> | |

Firma del Doctor _____, D.C.
Doctor Signature

10. Condición Médica:

Medical Conditions:

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> Artritis
<i>Arthritis</i> | <input type="checkbox"/> Cancer
<i>Cancer</i> | <input type="checkbox"/> Diabetes
<i>Diabetes</i> | <input type="checkbox"/> Enfermedad del Corazón
<i>Heart Disease</i> | <input type="checkbox"/> SIDA/VIH
<i>AIDS/HIV</i> |
| <input type="checkbox"/> Hipertensión
<i>Hypertension</i> | <input type="checkbox"/> Enfermedad Psiquiátrica
<i>Psychiatric Illness</i> | <input type="checkbox"/> Desorden de la Piel
<i>Skin Disorder</i> | <input type="checkbox"/> Derrame Cerebral
<i>Stroke</i> | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Osteoporosis
<i>Osteoporosis</i> | <input type="checkbox"/> Otro _____
<i>Other</i> | | | |

11. Cirugías:

Surgeries

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Apendicectomía
<i>Appendectomy</i> | <input type="checkbox"/> Procedimiento Cardiovascular
<i>Cardiovascular procedure</i> | <input type="checkbox"/> Columna Cervical
<i>Cervical spine</i> | <input type="checkbox"/> Histerectomía
<i>Hysterectomy</i> |
| <input type="checkbox"/> Reemplazo de Articulación
<i>Joint Replacement</i> | <input type="checkbox"/> Próstata
<i>Prostate</i> | <input type="checkbox"/> Espina Lumbar
<i>Lumbar spine</i> | <input type="checkbox"/> Vesícula Biliar
<i>Gall Bladder</i> |
| <input type="checkbox"/> Cerebro
<i>Brain</i> | <input type="checkbox"/> Hombro
<i>Shoulder</i> | <input type="checkbox"/> Columna Torácica
<i>Thoracic spine</i> | <input type="checkbox"/> Rodilla
<i>Knee</i> |
| <input type="checkbox"/> Túnel Carpiano
<i>Carpal Tunnel</i> | <input type="checkbox"/> Gastrointestinal
<i>Gastro-intestinal</i> | <input type="checkbox"/> Uro-genital
<i>Uro-genital</i> | <input type="checkbox"/> Hernia
<i>Hernia</i> |
| | | | <input type="checkbox"/> Otro _____
<i>Other</i> |

Ha tenido usted cualquier radiografía, CTs, IRMs u otra prueba especial en el último año? Si No
Have you had any X-Rays/CTs/MRIs or other special tests in the last year?

Ha tenido usted algún implante quirúrgico (marcapasos, tornillos, alfileres, clips o recambio de cadera/rodilla ? Si No
Do you have ANY surgical hardware or implants (Pacemakers/Screws/Pins/Clips or Hip/Knee replacement?)

12. Alergias:

Allergies:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Huevos
<i>Eggs</i> | <input type="checkbox"/> Pescado y Mariscos
<i>Fish and Shellfish</i> | <input type="checkbox"/> Leche o Lactosa
<i>Milk or Lactose</i> | <input type="checkbox"/> Cacahuates
<i>Peanuts</i> |
| <input type="checkbox"/> Soya
<i>Soy</i> | <input type="checkbox"/> Sulfitos
<i>Sulfites</i> | <input type="checkbox"/> Trigo/Gluten
<i>Wheat/Glutens</i> | <input type="checkbox"/> Otro _____
<i>Other</i> |

13. Medicamentos/Suplementos: (Lo que está tomando actualmente)

Medications/Supplements:

(what you are taking currently)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Presión Sanguínea
<i>Blood Pressure</i> | <input type="checkbox"/> Afinar la Sangre
<i>Blood Thinning</i> | <input type="checkbox"/> Artritis
<i>Arthritis</i> | <input type="checkbox"/> Vitaminas
<i>Vitamins</i> |
| <input type="checkbox"/> Colesterol
<i>Cholesterol</i> | <input type="checkbox"/> Terapia Hormonal
<i>Hormone Therapy</i> | <input type="checkbox"/> Medicamentos de Venta Libre
<i>Over-the-counter meds</i> | <input type="checkbox"/> Otro _____
<i>Other</i> |

14. Historial Social:

Social History:

- | | | | |
|--|---|--|--|
| Uso de Cafeína:
<i>Caffeine use</i> | <input type="checkbox"/> Ocasional
<i>occasional</i> | <input type="checkbox"/> A menudo
<i>often</i> | <input type="checkbox"/> Nunca
<i>never</i> |
| Uso de Alcohol:
<i>Drink Alcohol</i> | <input type="checkbox"/> Ocasional
<i>occasional</i> | <input type="checkbox"/> A menudo
<i>often</i> | <input type="checkbox"/> Nunca
<i>never</i> |
| Tabaco Masticado:
<i>Chew Tobacco</i> | <input type="checkbox"/> Ocasional
<i>occasional</i> | <input type="checkbox"/> A menudo
<i>often</i> | <input type="checkbox"/> Nunca
<i>never</i> |
| Cigarro:
<i>Cigarettes</i> | <input type="checkbox"/> 1<paquete/día
<i>occasional</i> | <input type="checkbox"/> 1>paquete/día
<i>often</i> | <input type="checkbox"/> Nunca
<i>never</i> |
| Ejercicio:
<i>Exercise</i> | <input type="checkbox"/> Ocasional
<i>occasional</i> | <input type="checkbox"/> A menudo
<i>often</i> | <input type="checkbox"/> Nunca
<i>never</i> |
| Uso cinturón de seguridad:
<i>Wear Seat Belts</i> | <input type="checkbox"/> Ocasional
<i>occasional</i> | <input type="checkbox"/> A menudo
<i>often</i> | <input type="checkbox"/> Nunca
<i>never</i> |

15. Historial de Familia:

Family History

- | | | | |
|---|--|---|---|
| Artritis:
<i>Arthritis</i> | <input type="checkbox"/> Padres
<i>Parent</i> | <input type="checkbox"/> Hermanos
<i>Sibling</i> | |
| Cancer:
<i>Cancer</i> | <input type="checkbox"/> Padres
<i>Parent</i> | <input type="checkbox"/> Hermanos
<i>Sibling</i> | |
| Diabetes:
<i>Diabetes</i> | <input type="checkbox"/> Padres
<i>Parent</i> | <input type="checkbox"/> Hermanos
<i>Sibling</i> | |
| Enfermedad Cardíaca:
<i>Heart Disease:</i> | <input type="checkbox"/> Padres
<i>Parent</i> | <input type="checkbox"/> Hermanos
<i>Sibling</i> | |
| Hipertensión:
<i>Hypertension</i> | <input type="checkbox"/> Padres
<i>Parent</i> | <input type="checkbox"/> Hermanos
<i>Sibling</i> | |
| Derrame Cerebral:
<i>Stroke</i> | <input type="checkbox"/> Padres
<i>Parent</i> | <input type="checkbox"/> Hermanos
<i>Sibling</i> | |
| Tiroides:
<i>Thyroid</i> | <input type="checkbox"/> Padres
<i>Parent</i> | <input type="checkbox"/> Hermanos
<i>Sibling</i> | <input type="checkbox"/> Otro _____
<i>Other</i> |

16. Historial de su Empleo:

Work History:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Administración
<i>Administration</i> | <input type="checkbox"/> Propietario de Negocio
<i>Business Owner</i> | <input type="checkbox"/> Oficina / Secretaria/o
<i>Clerical/Secretary</i> | <input type="checkbox"/> Ejecutivo/Legal
<i>Executive/Legal</i> |
| <input type="checkbox"/> Operador de Equipo Pesado
<i>Heavy Equip. Operator</i> | <input type="checkbox"/> Trabajo Manual Ligero
<i>Light Manual Labor</i> | <input type="checkbox"/> Construcción
<i>Construction</i> | <input type="checkbox"/> Usuario de Computadora
<i>Computer User</i> |
| <input type="checkbox"/> Industria de Alimentación
<i>Food Service Industry</i> | <input type="checkbox"/> Trabajo Manual Medio
<i>Medium Manual Labor</i> | <input type="checkbox"/> Guardería/Cuidado de Niños
<i>Daycare/Childcare</i> | <input type="checkbox"/> Servicios del Hogar
<i>Home Services</i> |
| <input type="checkbox"/> Fabricación
<i>Manufacturing</i> | <input type="checkbox"/> Trabajo Manual Pesado
<i>Heavy Manual Labor</i> | <input type="checkbox"/> Salud
<i>Health</i> | <input type="checkbox"/> Ama de Casa
<i>Housekeeper</i> |
| | | | <input type="checkbox"/> Otro _____
<i>Other</i> |

Firma del Doctor _____, D.C.
Doctor Signature

Qué tipo de actividades hace en su trabajo?

What types of activities does your job involve?

- Sentado En Pie Inclinado Tornado Retortijón Levantando Tirando / Empujando Otro _____
Sitting Standing Bending Turning Twisting Lifting Pulling/Pushing Other

17. Esta embarazada ahora? Si No Si, si fecha de nacimiento aproximado _____
Are you currently pregnant? Yes No If yes, Due Date:

18. Usted utiliza un marcapasos? Si No
Do you have a pacemaker? Yes No

Revisión y Consentimiento

Review & Consent

He leído la información posterior y certifico que es verdad y correcta a lo mejor de mi sabiduría, y por lo presente autorizo a esta oficina de Quiropráctico para proveerme cuidado Quiropráctico, de acuerdo con las leyes de este estado. Yo entiendo que es mi responsabilidad traer atención al medico CUALQUIER nueva información con respecto a mi salud y bien estar o algun cambio en mi estado de salud que sea pertinente al manejo de mi caso. Como cualquier procedimiento del cuidado de salud, hay ciertas complicaciones que pueden surgir durante la terapia y manipulación quiropráctica. Algunos pacientes sentirán rigidez y dolor muscular despues de los primeros días del tratamiento. El doctor hara todo lo razonablemente posible durante la examinación para investigar cualquier contraindicaciones del cuidado; sin embargo si Usted tiene una condición que de otro modo no vendría a nuestra atención, es su responsabilidad informarnosla.

Firma del paciente _____ Fecha _____
Patient Signature Date

Firma de Padres o Tutor Legal _____ Fecha _____
Parent or Guardian Signature Date

Firma del Doctor _____, D.C.
Doctor Signature

To: _____



**Hooper-Thurston
Elite Chiropractic**
A Member of Elite Chiropractic Centers
806 W. Hines St. Wilson, NC 27893
Office: 252.237.2166 Fax: 252.237.2167

MEDICAL AUTHORIZATION

I hereby consent and request that my chiropractic physicians, at Hooper-Thurston Elite Chiropractic of Wilson, North Carolina, be permitted to examine and obtain copies of all hospital and medical records of every sort and kind, interview all doctors and other attendants, and all employees and former employees regarding all matters relating to examination, diagnosis, care and treatment of myself. This authorization also includes all information from x-ray films to which you have access.

I understand that I may revoke this Authorization at any time except to the extent that action has been taken in reliance on it. If I revoke this authorization, I must do so in writing. The process for revoking this authorization is to notify our facility in writing that you wish to revoke this authorization.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law.

I have read or have had read to me the above authorization and understand it. My signature ensures that I am the patient named or the patient's legally authorized representative.

I authorize the use of a copy (including an electronic or faxed copy) of this form.

This authorization expires automatically upon one year after date signed.

This _____ day of _____, _____.

Patient or Guardian Signature

Patient's Name: _____

Address: _____

Birth Date: _____

Records from: _____



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Effective April 14, 2003

HIPAA

(Health Insurance Portability and Accountability Act of 1996)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH 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 Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. "Protected Health Information" is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your Protected Health Information may be used and disclosed by your physician, our office 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, to pay your health care bills, to support the operation 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, or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and 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.

HEALTH CARE OPERATIONS: We may use or disclose, as needed, your Protected Health Information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. In addition we may use a sign-in sheet at the registration desk, we may provide you with appointment reminders and other necessary medical information by postcards or letters, voicemail messages at home, and requests for a return telephone call at your place of employment. We may also call you by name in the waiting room when your physician is ready to see you.

SPECIAL SITUATIONS

As required by law we will disclose your Protected Health Information when required to do so by international, federal, state or local authorities. Such situations include, but are not limited to, **Averting a Serious Threat to Health or Safety of the public; Business Associates** (disclosure to those who perform functions on our behalf, such as our billing company), **Organ and Tissue Donation; Military and Veterans; Workers' Compensation; Public Health Risks; Health Oversight Activities; Lawsuits and Disputes; Law Enforcement; Coroners, Medical Examiners, and Funeral Directors; National Security and Intelligence Activities; Protective Services for the President and Other Authorized Persons; Inmates or Individuals in Custody.**

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 the extent that your physician or practice has taken an action in reliance on the use or disclosure indicated in the authorization.

