Hooper-Thurston
Elite Chiropractic

DR. MARK HOOPER
DR. MARK THURSTON

Patient _____
(First) (Middle) (Last)

Address _____

City _____ State _____ Zip _____

E-mail address _____

Home Phone # _____ Cell Phone # _____

Would you like an appointment reminder? Text( ) Call( )

Date of Birth _____ Age _____
(Month) (Day) (Year)

Social Security # _____

Patient Employer (Parent or Legal Guardian) _____

Single( ) Married( ) Spouse's Name _____

Emergency Contact (Parent or Legal Guardian) _____

Relationship to Patient _____ Phone # _____

Work Phone # _____

Hobbies _____

Complaint _____

Is complaint accident related? Yes( ) No( ) Date accident occurred _____

Work related( ) Auto related( ) Other( ) _____

Payment Is Expected At Time Of Visit Unless Other

Arrangements Are Made In Advance

_____ **X** _____
Date Patient's Signature
(Parent or Legal Guardian Signature)

Hooper-Thurston Elite Chiropractic
A Member of Elite Chiropractic Centers

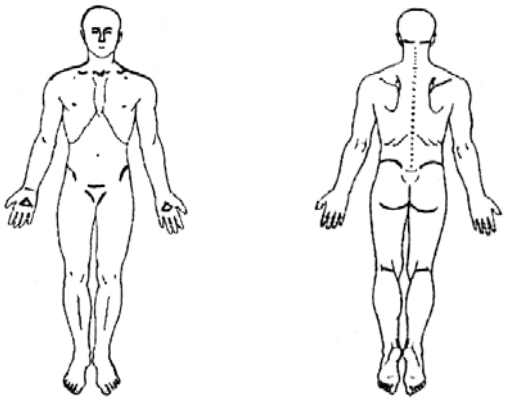
PATIENT HISTORY

Patient Name: _____ Date: _____

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

Current Symptoms: _____

1. Location *(Where does it hurt?)* Circle the area(s) on the illustration



2. Symptoms

- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Cramps
- ☐ Nagging
- ☐ Sharp
- ☐ Burning
- ☐ Shooting
- ☐ Throbbing
- ☐ Stabbing
- ☐ Other

3. Intensity
(What does it feel like?)

○--○--○--○--○--○--○--○--○--○

1 2 3 4 5 6 7 8 9 10

Absent Uncomfortable Agonizing

4. Duration & Timing When did it start? _____ *How often do you feel it*? ☐Constant ☐Comes and goes

5. Radiation *(Does it affect other areas of your body? and what areas does the pain radiate, shoot or travel?)*

_____

6. Aggravating or relieving factors *(What makes it better or worse, such as time of day, movements, certain activities, etc.)*

_____

7. Prior interventions *(What have you done to relieve the symptoms?)*

☐ Prescription medication	☐ Surgery	☐ Ice
☐ Over-the-counter drugs	☐ Acupuncture	☐ Heat
☐ Homeopathic remedies	☐ Chiropractic	☐ Other_____
☐ Physical Therapy	☐ Massage	

8. What else should the doctor know about your current condition?

_____

9. Do you CURRENTLY experience ANY of the following?: Date of last Physical Examination: _____

☐ Urinary Problems	☐ Bowel Problems	☐ Night Sweats	☐ Fever	☐ Muscle Cramping
☐ Skin Rashes	☐ Blood Clotting Issues	☐ Sensitivity to Cold	☐ High Cholesterol	☐ Diminished Sex Drive
☐ Fainting	☐ Muscle Cramping	☐ Recurrent Infection	☐ Fatigue Easily	☐ Stomach Problems
☐ Migraines	☐ Kidney Problems	☐ Depression	☐ Anxiety	☐ Menstrual Irregularities
☐ Bladder Problems	☐ Weight Loss	☐ Chronic or Frequent	☐Cough	☐ Prostate Problems
☐ Dizziness/Vertigo	☐ Chest Pain	☐ Other _____		

10. Medical Conditions:

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease	☐ AIDS/HIV
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke	☐ Hepatitis
☐ Osteoporosis	☐ Other _____			

Doctor Signature _____, D.C.

Patient Name: _____ Date: _____

11. Surgeries:

☐ Appendectomy ☐ Cardiovascular procedure ☐ Cervical spine ☐ Hysterectomy
☐ Joint Replacement ☐ Prostate ☐ Lumbar spine ☐ Gall Bladder
☐ Brain ☐ Shoulder ☐ Thoracic spine ☐ Knee
☐ Carpal Tunnel ☐ Gastro-intestinal ☐ Uro-genital ☐ Hernia ☐ Other _____

Have you had any X-Rays/CTs/MRIs or other special tests in the last year? ☐ Yes ☐No
Do you have ANY surgical hardware or implants (Pacemakers/Screws/Pins/Clips or Hip/Knee replacement?) ☐Yes ☐ No

12. Allergies:

☐ Eggs ☐ Fish and Shellfish ☐ Milk or Lactose ☐ Peanuts
☐ Soy ☐ Sulfites ☐ Wheat/Glutens ☐ Other _____

13. Medications/Supplements: *(what you are taking currently)*

☐ Blood Pressure ☐ Blood Thinning ☐ Arthritis ☐ Vitamins
☐ Cholesterol ☐ Hormone Therapy ☐ Over-the-counter meds ☐ Other _____

14. Social History:

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Chew Tobacco:	☐ occasional	☐ often	☐ never
Cigarettes:	☐ <1 pack/day	☐ >1 pack/day	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Wear Seat Belts:	☐ occasional	☐ always	☐ never

15. Family History:

Arthritis:	☐ Parent	☐ Sibling	
Cancer:	☐ Parent	☐ Sibling	
Diabetes:	☐ Parent	☐ Sibling	
Heart Disease:	☐ Parent	☐ Sibling	
Hypertension:	☐ Parent	☐ Sibling	
Stroke:	☐ Parent	☐ Sibling	
Thyroid:	☐ Parent	☐ Sibling	Other _____

16. Work History:

☐ Administration ☐ Business Owner ☐ Clerical/Secretary ☐ Executive/Legal
☐ Heavy Equip. Operator ☐ Light Manual Labor ☐ Construction ☐ Computer User
☐ Food Service Industry ☐ Medium Manual Labor ☐ Daycare/Childcare ☐ Home Services
☐ Manufacturing ☐ Heavy Manual Labor ☐ Health ☐ Housekeeper ☐ Other _____

What types of activities does your job involve?

☐ Sitting ☐ Standing ☐ Bending ☐ Turning ☐Twisting ☐ Lifting ☐ Pulling/Pushing ☐ Other _____

17. Are you currently pregnant? ☐ Yes ☐ No If yes, Due Date: _____

18. Do you have a pacemaker? ☐ Yes ☐ No

Review & Consent

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. I understand that it is my responsibility to bring to the attention of the providing physician ANY new information regarding my health and well-being or any changes in health status that would be pertinent to my case management.
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Some patients will feel some stiffness and soreness following the first few days of treatment. The doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

Patient Signature X_____ Date_____

Parent or Guardian Signature _____ Date_____

Doctor Signature _____, D.C.

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 _____, _____.

X_____

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.

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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.

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YOUR RIGHTS

The following is a statement of your rights with respect to your Protected Health Information.

You have the right to inspect a copy of your Protected Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records. Under Federal Law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. If you request a copy of your Protected Health Information, we may charge a reasonable fee for the copying, postage, labor and supplies used in meeting your request.

You have the right to request restrictions of your Protected Health Information which means you have the right to ask us not to use or disclose any part of your Protected Health Information for the purposes of treatment, payment or healthcare operations. You also have the right to request a limit on the Protected Health Information we disclose to someone involved in your care or the payment for your care, such as a family member or friend. To request a restriction, you must make your request in writing to the Practice Manager. **We are not required to agree to your request** if the physician believes it is in your best interest to permit use and disclosure of your Protected Health Information. You then have the right to use another Healthcare Professional.

You have the right to request confidential communication regarding medical matters be given to you in a certain way or at a certain location. This request must be made in writing to the Practice Manager. Your request will specify how or where you wish to be contacted. We will accommodate reasonable requests.

You have the right to have your physician amend your Protected Health Information. If you feel that your Protected Health Information we have is incorrect, or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. This request must be made in writing to our Practice Manager.

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to Protected Health Information we already have as well as any Information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

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We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to Protected Health Information.

Signature below is only acknowledgment that you have received this **NOTICE of our PRIVACY PRACTICES.**

_____	X _____	_____
Print Name	**Signature**	**Date**