Hooper-Thurston
Elite Chiropractic
A Member of Elite Chiropractic Centers

DR. MARK HOOPER
DR. MARK THURSTON

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

_____ X _____
Fecha Firma Del Paciente

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Reporte De Accidente

Nombre del paciente: _____ **Fecha:** _____

Fecha del accidente de auto _____

A sido usted un paciente aqui antes? ☐ **Si** ☐ **No**
Have you been a patient here before? Yes No

En el accidente, era Usted el: ☐ **Conductor** ☐ **Pasajero** ☐ **Peatón**
In the auto accident, were you the: Driver Passenger Pedestrian

Si Usted era pasajero, por favor indique su posición en el vehiculo?
If you are a passenger please **locate** your position in the vehicle:

☐ **Aciento delantero** ☐ **Atras de pasajero** ☐ **Atras del conductor**
Front Seat Back Seat Passenger side Back Seat Driver Side

Eran Usted consicenter del choque inminete? ☐ **Si** ☐ **No**
Were you aware of the impending crash? Yes No

En el carro enque usted establa: ☐ **Parado** ☐ **Movimiento**
Was the car that you were in: Stopped Moving

Indique dondo el auto en el que estba sufrió el primer impacto:
Where did the car that you were in first sustain impact?

☐ **Golpiado por delante** ☐ **Impacto frontal derecho** ☐ **Lado dercho traser** ☐ **Golpes multiples**
front-end impact right side front right side rear Multiple impacts

☐ **Golpiado por detras** ☐ **Lado izquiredo traser** ☐ **Impacto frontal izquierda** ☐ **No recureda**
rear-end impact left side front left side rear Don't remember

Estaba usted usando el cinturun de sequirdad? ☐ **Si** ☐ **No**
Were you wearing a seat belt? Yes No

Se desplegó la bolsa de aire? ☐ **Si** ☐ **No**
Did the air bag deploy? Yes No

Tras el impacto, hacia donde se veía tu cabeza?
Upon impact which way was your head turned?

☐ **Izquierda** ☐ **Derecha** ☐ **Al Frente** ☐ **Mirando abajo** ☐ **No Recuerda**
To Left To Right Straight Ahead Looking Down Don't Remember

Estaban sus manos en el volante? ☐ **Mano Izquierda** ☐ **Mano Derecha** ☐ **Ambas Manos**
Were your hands on the steering wheel? Left hand Right hand Both hands

Golpeaste alguna parte de su cuerpo? ☐ **Si** ☐ **No**
Did you strike any portion of your body? Yes No

Si, sí que parte del cuerpo golpio?
If yes, which portion of your body did you strike?

☐ **Cabeza** ☐ **Rodilla** ☐ **Brasoz** ☐ **Manos** ☐ **Hombros** ☐ **Otro** _____
Head Knee Arms Hands Shoulders Other

Que objetos golpio?
What objects did you strike?

☐ **Volante** ☐ **Tablero** ☐ **Espejo Retrovisor** ☐ **Consola Central** ☐ **Bolsa de aire**
Steering Wheel Dash Board Rearview Mirror Center Console Air Bag

☐ **Ventana lateral** ☐ **Parabrisas** ☐ **Puetra Lateral** ☐ **Apoyo para la cabeza** ☐ **Ortor**_____
Side Window Windshield Side Door Headrest Other

Despues del accidente estaba usted?
After the accident were you?

☐ **Aturdido** ☐ **Incosiente** ☐ **Cortado** ☐ **Magullado** ☐ **Abrasiónes/Raspado**
Dazed Unconscious Cut Bruised Abrasions/Scrapes

Experimento Ústed?
Did you experience?

☐ **Dolor Inmediato** ☐ **Dolor Gradual** ☐ **Ritmo Cardiaco Elevado** ☐ **Hipertension** ☐ **Respiracion Rapida**
Immediate Pain Gradual Pain Rapid Heart Rate High Blood Pressure Rapid Breathing

Algunos de estos sintomas estaban ya presents antes del accident? ☐ **Si** ☐ **No** **Si, sí por favor describa?** _____
Were any of the listed symptoms present before the accident? Yes No If YES, please describe?

Fue a la sala de emergencias, cuidado urgente o doctor? ☐ **Si** ☐ **No** **Cuando** _____ **Dónde** _____
Did you go to the Emergency Room, Urgent Care or Doctor? Yes No When Where

Como llego? ☐ **Ambulancia** ☐ **Me Conduje** ☐ **Amigo/ Familiar**
How did you get there? Ambulance Drove myself Friend/Relative

Que procedimientos fueron hechos en la sala de emergencias/cuidado urgente?
What procedures were done in the Emergency Room/Urgent Care?

☐ **Examinación** Examination ☐ **Putadas** Stitches ☐ **Rayos-X** X-rays ☐ **Collarín** Collar ☐ **Relajantes Musculars** Muscle Relaxers
☐ **Pastillas para el dolor** Pain Pills ☐**Riostra/Apoyo** Brace ☐ **Ortor**_____ Other

Se quedo la noche en la sala de emergencias/ Cuidado urgente? ☐ **Si** Yes ☐ **No** No
Did you stay the night in the Emergency Room/Urgent Care?

A visto a otro medíco para este problema? ☐ **Si** Yes ☐ **No** No
Have you seen any other Physicians for this problem?

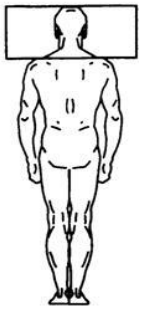
Esta tomando otro medicamento en este momento si, si por favor listé? ☐ **Si** Yes ☐ **No** No
Are you taking any medications?

Esta embarazada? ☐ **Si** Yes ☐ **No** No **Si, sí que fecha dara luz** _____
Are you pregnant? If yes, Due Date

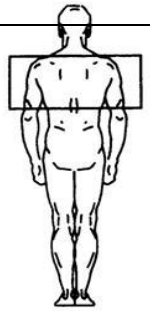
Tiene usted un marcapasos o algun otro metal en su cuerpo? ☐ **Si** Yes ☐ **No** No
Do you have a pacemaker or any metal in your body?

INDIQUE LOS SINTOMAS NOTADOS DESDE EL ACCIDENTE

CABEZA Y CUELLO/ HEAD & NECK

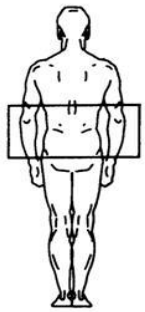


☐ **Dolor de cuello** Neck pain ☐ **Dolor de cabesa** Headaches ☐ **Náusea** Nausea ☐ **Peridad de balance** Loss of balance ☐ **Porbe concentracion** Poor concentration
☐ **Rigidez del cuelle** Neck stiffness ☐ **Mareps** Dizziness ☐ **Irritable** Irritable ☐ **Zumbido en el odíos** Ringing in ears ☐ **La cabeza parece pesada** Head seems heavy
☐ **Espasmos en el cuello** Neck spasms ☐ **Depression** Depression ☐ **Fatiga** Fatigue ☐ **Problemas para dormir** Sleeping problems ☐ **Problemas visuales** Visual problems
☐ **Dolor de mano** Hand pain ☐ **Entumecimiento / hormigueo en la mano** Numbness/tingling hand ☐ **Problemas de memoria** Memory problems
☐ **Dolor de brazos** Arm pain ☐ **Entumecimiento / hormigueo en el brazo** Numbness/tingling arm ☐ **Ojos sensibles a la luz** Eyes sensitive to light
☐ **Dolor de hombres** Shoulder pain ☐ **Entumecimiento / hormigueo en el hombro** Numbness/tingling shoulder ☐ **Sensación de rechinar en el cuello** Grinding sensation in neck



MEDIA ESPALDA MID BACK & CHEST

☐ **Dolor a media espalda** Mid back pain ☐ **Rigidez a media espalda** Mid back stiffness ☐ **Toz aumenta dolor** Coughing increases pain
☐ **Respiración corta** Shortness of breath ☐ **Estornudos aumentan dolor** Sneezing increases pain
☐ **Espasmos en media espalda** Mid back spasms ☐ **Dolor en costillas/lados** Rib/side Pain
☐ **Dolor de pecho** Chest pain ☐ **La respiracion aumenta el dolor** Breathing increases pain



☐ **Dolor de espalda baja** Low back pain ☐ **Dolor de cadera** Hip pain ☐ **Entumecido/hormigue en la cadera** Numbness tingling in hip
☐ **Rigidez en la espalda baja** Low back stiffness ☐ **Dolor de muslo** Thigh pain ☐ **Entumecimiento hormigueo en el muslo** Numbness tingling in thigh
☐ **Espasmos en la espalda baja** Low back spasms ☐ **Dolor en la pierna** Lower leg pain ☐ **Entumecido/hormigue en en pie / tobillo** Numbness tingling in lower foot/ankle
☐ **Dolor de pie / tobillo** Foot/ankle pain ☐ **Entumecido/hormigue en la parte inferior de la pierna** Numbness tingling in lower leg

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_____

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**