Kouch Chiropractic
63 South Main Street · Natick, MA 01760
Dr. Pheng Kouch · (508) 654-3500

Your appointment has been scheduled for ____

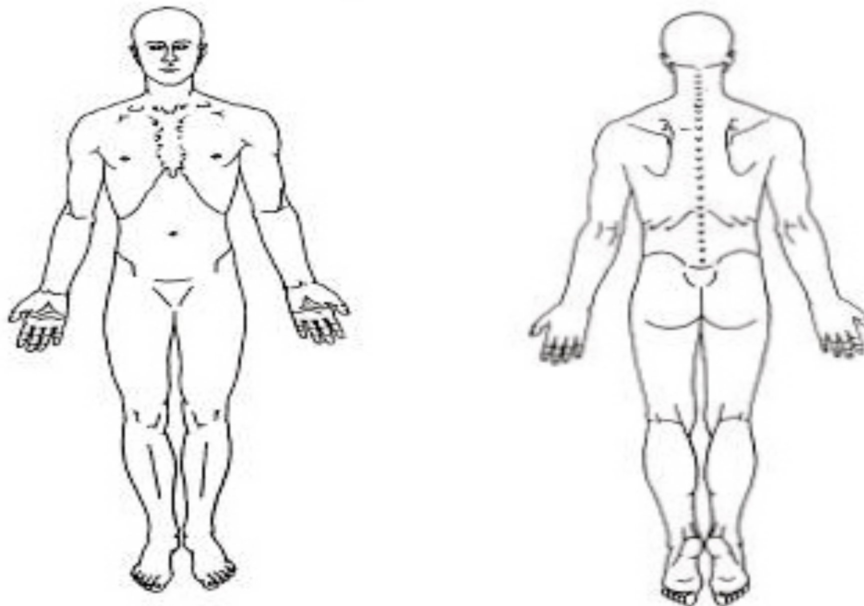
Please take the time to fill out this questionnaire carefully and bring this with you to your appointment. *All of your answers will be kept completely confidential*. If you have any questions, please ask. If there is any additional information that you feel is relevant, please alert your chiropractor.

GENERAL & CONTACT INFORMATION			
Name			Date
Home Phone	Cell Phone		
Email Address			Date of Birth
Street		Age	Occupation
City			Weight
State	Zip		Height
Family Physician	Phone		Marital Status
Insurance Company			Referred By

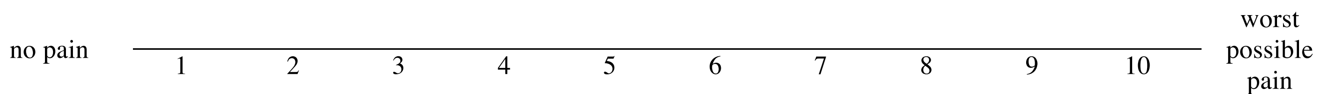
INFORMATION ABOUT CURRENT PROBLEM(S)
Main problem(s) you would like us to help you with:
What seemed to be the initial cause?
How long ago did this problem begin? Please be specific.
Have you had this problem previously? If yes, when?
To what extent does this problem interfere with your daily activities? (Work, sleep, etc.)
Have you been given a diagnosis for this problem? If so, what?
Have you had any recent trauma? (Auto accidents, falls, etc.)
What kind of treatment(s) have you tried? Were they helpful?
Have you been treated with chiropractic care before?
Have you had X-rays, MRIs, or CT scans? If yes, what body part(s) and when?
Medicines taken in the past three months? (Including vitamins, herbs, and OTC medications)

What makes your pain worse? (Sitting, walking, etc.)
What makes your pain better? (Heating pad, lying down, medications, etc.)
Is your pain constant or intermittent?
Is your pain worse at a particular time of day?

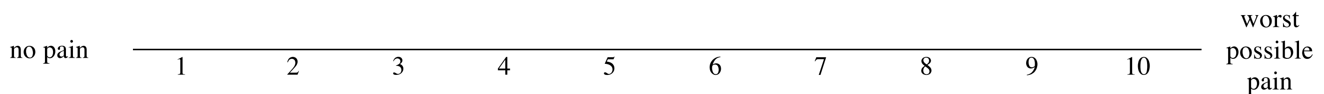
Please indicate where your pain is located. Mark “xxxx” to denote areas of sharp pain, “dddd” for areas of dull pain, and “zzzz” for areas of numbness and tingling. Please note radiating or shooting pain and areas of muscle weakness on the diagram.



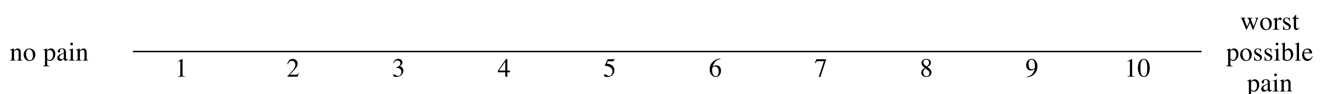
Please rate your pain AT THE MOMENT.



Please rate your AVERAGE pain level in the last three weeks.



Please rate your pain AT ITS WORST.



PLEASE CHECK IF YOU HAVE HAD (in the last three months):

General
__ Significant weight loss
__ Significant weight gain
__ Fevers
__ Chills
__ Rashes
__ Trouble sleeping
__ Allergies (drugs, chemicals, foods)
__ Recent surgeries (if yes, where?) ________________

Significant Illnesses
__ Cancer
__ Diabetes
__ Hepatitis
__ High blood pressure
__ Heart disease
__ Thyroid disease
__ Seizures
__ S.T.D.
__ Other (please explain)

Head, eyes, ears, nose, and throat
__ Headaches (where, when?)
__ Dizziness
__ Migraines
__ Eye strain
__ Concussion
__ Spots in front of eyes
__ Eye pain
__ Glasses
__ Earaches
__ Sinus problems
__ Grinding teeth
__ Jaw clicks
__ Facial pain
__ Ringing in ears
__ Any other head or neck problems?

Cardiovascular
__ High blood pressure
__ Low blood pressure
__ Irregular heartbeat
__ Swelling of hands or feet
__ Cold hands or feet
__ Difficulty breathing
__ Fainting
__ Chest pain
__ Any other heart or blood vessel problems?

Respiratory
__ Asthma
__ Difficulty breathing when lying down
__ Any other respiratory problems?

Gastrointestinal
__ Nausea
__ Constipation
__ Abdominal pain or cramps
__ Blood in stools
__ Any other problems with your stomach or intestines?

Reproductive and Gynecologic
Number of pregnancies _____
Number of live births _____
__ Irregular periods
__ Unusual periods (heavier, lighter, etc.)
__ Menstrual pain
__ Spotting or pain between periods
Changes in body / psyche prior to period: ______________________
____
Is there any chance that you are pregnant now? Yes No

Genito-Urinary
__ Inability to hold urine
__ Sudden urgency to urinate
__ Sores on genitals
__ Impotence
__ Decrease in urine flow
__ Kidney stones
__ Blood in urine
How many times per day do you urinate? ____________________
Do you wake up to urinate? If so, how often? _________________

Musculoskeletal
__ Neck pain
__ Back pain
__ Hip pain
__ Knee pain
__ Foot / ankle pains
__ Shoulder pain
__ Hand / wrist pains
__ Muscle weakness
__ Muscle pain
__ Muscle pain with menses
__ Headaches with menses
__ Any other joint or bone problems?

Neuropsychological
__ Tremors
__ Lack of coordination
__ Loss of balance
__ Depression
__ Anxiety
__ Susceptibility to stress
__ Poor memory
__ Have you ever been treated for emotional problems?
__ Any other neurological or psychological problems?

FAMILY MEDICAL HISTORY (circle all that apply)

Cancer	Diabetes	High Blood Pressure	Heart Disease	Stroke
Seizures	Asthma	Allergies	Other: ____________________	

LIFESTYLE AND HABITS

Do you typically sleep on your back, side, or stomach?

What do you do for most of the day? (Sitting, standing, lifting, etc.)

Do you have a regular exercise program? If yes, please describe.

How many glasses of water do you drink per day?

Do you smoke? If yes, how much per day?

ADDITIONAL QUESTIONS

Is there any pain when you cough or sneeze?

Is there any numbness or tingling in your hands or feet?

Does your pain wake you up at night?

Have you had any unexplained weight loss?

Are you having any bowel or bladder incontinence?

Do you have any significant muscle weakness?

Have you had any recent fevers or illnesses?

INFORMED CONSENT

The primary treatment used by doctors of chiropractic is the spinal adjustment, otherwise known as manipulation. I will use my hands or a mechanical device (activator) upon your body in such a way as to move your joints. This may cause an audible "pop" much as you have experienced when you crack your knuckles. As with any healthcare procedure, there are certain complications that may arise during a chiropractic adjustment. The most frequent complication involves stiffness or soreness following the first few days of treatment. Less frequently, complications can arise which include muscle strain or separation of the ribs. Even more rare are injuries to the discs, joint dislocation, or fractures or injuries to the spinal nerves or arteries that can cause weakness or paralysis. In addition to chiropractic adjustments, I may also use massage, stretching, or active release techniques. These soft tissue therapies are beneficial but do carry the risk of soreness in the treated areas. Remaining untreated allows the formation of adhesions, which may reduce mobility. Over time, this process may complicate treatment, making it more difficult, less effective, and prolonged. This risk of complication from remaining untreated is high.

I have read and fully understand the information above.

Patient Signature: ____ Date: ________________

Functional Rating Index

For use with Neck and/or Back Problems only

In order to properly assess your condition, we must understand how much your neck and back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
NoPain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed sleep	Totally Disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain No restrictions	Mild pain no restrictions	Moderate pain, need to go slowly	Moderate pain, need some assistance	Severe pain, need 100% assistance

4. Travel (driving, etc)

0	1	2	3	4
No pain on Long trips	Mild pain on long trips	Moderate pain on long Trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do Usual work Plus unlimited Extra work	Can do usual work, no extra	Can do 50% of Usual work	Can do 25% of usual work	Cannot Work

6. Recreation

0	1	2	3	4
Can do all Activities	Can do Most Activities	Can do some Activities	Can do a few Activities	Cannot do any activities

7. Frequency of Pain

0	1	2	3	4
No Pain	Occasional pain – 25% of the day	Intermittent pain – 50% of the day	Frequent pain – 75% of the day	Constant pain 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Incrased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Name:____ (PRINTED)

Score:_________

____
Signature

____
Date

INSURANCE INFORMATION
Complete and accurate information is required.

PATIENT		
Name		
Address		
City	State	Zip Code
Date of Birth	Sex	Marital Status
Home Phone	Cell Phone	

RESPONSIBLE PARTY	Person responsible for any balance not covered by insurance
__ Same as patient __ Other	
Name	
Address	
Home Phone	Cell Phone

INSURANCE	Attach copy of front and back of insurance card
Primary Insurance	
Subscriber #	Group #
Secondary Insurance	
Subscriber #	Group #

SUBSCRIBER	
__ Same as patient __ Same as responsible party __ Other	
Subscriber Name	Date of Birth
Patient Relationship to Subscriber: __ Self __ Spouse __ Other (specify)	
Employer	Employer Phone

INSURANCE AUTHORIZATION AND ASSIGNMENT	
I hereby authorize the Provider of Service to furnish information to insurance carriers concerning my condition and treatment. I hereby assign to the Provider all payments for medical services rendered to my dependents of myself. I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.	
Signature	Date

NOTICE OF HEALTH INFORMATION PRACTICES

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

Introduction
At Kouch Chiropractic, we are committed to treating and using protected health information about you responsibly. This Notice of Health Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information as defined by federal regulations.

Understanding your Heath Record/Information
Each time you visit Kouch Chiropractic, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third party can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and nation,
- A source of data for our planning and marketing, and
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights
Although your health record is the physical property of Kouch Chiropractic, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternate locations,
- Request a restriction on certain uses and disclosures of your information as provided in 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action as already been taken.

Our Responsibilities
Kouch Chiropractic is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We may use and disclose your information without your written authorization for the following purposes, and as otherwise permitted or required by law:

- Treatment: to help health care providers provide, coordinate, or manage your health care. For example, to refer you to another provider.
- Payment: to obtain payment for services rendered or for you to receive reimbursement from a third party payer for payments you have made to the office.
- Health care operations, including

  Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. We may leave messages on an answering machine or with a person at the phone numbers you have provided to us.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
Law enforcement: We may disclose health information for law enforcement purposes as required by law or in person to a valid subpoena

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

We will not use or disclose your health information without your authorization, except as described in this notice. We will not disclose your health information including scheduling and billing to a spouse, children, friends, attorneys, or other "representative" without a signed consent. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to procedures included in the authorization.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied to us.

For More Information or to Report a Problem
If you have questions and/or would like additional information, you make contact the privacy officer, Dr. Kouch, directly at (617) 257-5180.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Heath and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The Address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I, ______________________________, understand that as part of my health care, Kouch Chiropractic originates and maintains paper and electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Health Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Kouch Chiropractic is not required to agree to the restrictions I have requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent, the organization my refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Kouch Chiropractic reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.20 of the Code of Federal Regulations. Should Kouch Chiropractic change their notice, they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

I fully understand and accept the terms of this consent.

____
Patient's Signature

____
Date

FOR OFFICE USE ONLY

___ Consent received by ______________________________________ on _________________.
___ Consent refused by patient, and treatment refused as permitted.
___ Consent added to the patient's medical record on _________________.