INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____________

PATIENT INFORMATION

Name: (Last, First MI)____ **Preferred Name**: _________________

Address: ____ **City:** _______________________ **State:** _______ **Zip:** ___________ **Home:** _________________ **Mobile:** _________________ **Mobile Carrier:** ____________________ **Work:** _________________

Email: ____ **Gender:** M / F **Marital Status:** Married / Other / Single

Social Security #:__________________________________ ______ **Date of Birth:** ____________________________________

***Referred By:** ____

 # Children & Name:_____________________________________ □ **Employed** **Employer:** _______________________

Ethnicity: Hispanic or Latino / Other

Race: Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White

Preferred Language: _______________________________

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _______________________________________

Home: _________________ **Mobile:** _________________

Relationship: Child / Parent / Spouse / Other: ____________

Primary Care Physician: ___________________________

Doctor's Phone: __________________________________

FINANCIAL INFORMATION

□ Insurance □ Worker's Comp □ Self-Pay (Cash) □ Personal Injury/Auto □ Other (please explain):_________

PRIMARY INSURANCE

Name: ____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: ______________________ **Gender:** M / F

Address: ____

City: ___________________ **State:** _____ **Zip:** _________

Phone: ___________________ **Date of Birth:** ___________

SECONDARY INSURANCE

Name: ____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: ______________________ **Gender:** M / F

Address: ____

City: ___________________ **State:** _____ **Zip:** _________

Phone: ___________________ **Date of Birth:** ___________

Who is responsible for payment? Self / Other - *(Relationship)* ___________________________

Other than Self:

Full Name: _______________________________________ **Phone:** ___________________

Address: ____ **City:** ____________________ **State:** _______ **Zip:** ___________

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient No: ___________

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PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: ____

Began When? ____/_____/______ **Describe how this began:**____

____

____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: __________________________

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)*_________________________________

<u>*Head*</u> - Base of Skull / Forehead / Sides-Temple R / L / Both   <u>*Leg*</u> - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

<u>*Arm*</u> - Across Shoulder / Elbow / Hand-Fingers R / L / Both   <u>*Other Area:*</u> ___________________________________

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: ______________________ **Does anything make the complaint worse?** Sit / Stand / Walk / Lying / Sleep / Overuse / Other: __________________________ **Which daily activities are being affected by this condition?** *(Describe)* ____

<u>For this CURRENT condition, have you:</u>

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: ____________ **Where?** _______________
- **Had any previous Surgery or Interventions in this area?** *(Describe)*____
- **Taken any Medications?** OTC / Prescriptions ____
- **Had any diagnostic testing?** X-rays / MRI / CT / Other: ____________ **When and Where?** _____________________

Describe any Secondary Complaints: ____

HEALTH HISTORY - (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED*)

<u>*Medications:*</u>

Allergies to Medications: ***NONE*** *(List)* _______________

____

Current Medications: ***NONE***
*(Already have a list? We can make a copy.)*_______________

____

____

____

____

<u>*Past Health History:*</u> *(Please list any past…)*

Surgeries - Date, Type, and Reason: ***NONE***

____

____

____

____

Major Injuries/Traumas: ***NONE*** ___________________

____

____

____

Major Hospitalizations: ***NONE*** ____________________

____

____

<u>*Family Health History:*</u> *(Please mark N/A if not relevant.)*

List *relevant* major health problems of immediate relatives:

____

____

____

Deaths in immediate family: *(Cause and at what Age?)*

____

____

____

<u>*Social and Occupational History:*</u>

Level of Education Completed: ____________________

High School / Some College / College Grad. / Post Grad. / Other

Lifestyle: *(Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)*

____

____

____

____

Habits:

Cigarettes - *(#/day)* ___________________________

Alcohol - *(amount/day)*__________________________

Coffee/Tea - *(cups/day)*_________________________ Rec.

Drugs *(List)*_________________________________

Patient No: __________

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Are you *currently* experiencing any of these symptoms? *(Check all the apply)*

Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: *(constitutional)*

- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ *None in this Category*

Musculoskeletal:

- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems ________________
- ☐ Leg Problems ________________
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones________________
- ☐ Other: ______________________
- ☐ *None in this Category*

Neurological:

- ☐ Numbness or tingling sensations
- ☐ Loss of Feeling
- ☐ Dizziness or light headed
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Have you ever had a head injury?
- ☐ Ever been in an auto accident?
- ☐ Other: ______________________
- ☐ *None in this Category*

Mind/Stress:

- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: ______________________
- ☐ *None in this Category*

Genitourinary:

- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/strain w Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: ______________________
- ☐ *None in this Category*

Gastrointestinal:

- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: ______________________
- ☐ *None in this Category*

Cardiovascular & Heart:

- ☐ Chest Pains
- ☐ Rapid or Heartbeat changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ Other: ______________________
- ☐ *None in this Category*

Respiratory:

- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other: ______________
- ☐ *None in this Category*

Eyes and Vision:

- ☐ Wear contacts/glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other: ______________________
- ☐ *None in this Category*

Ears, Nose and Throat:

- ☐ Bleeding gums / mouth sores
- ☐ Bad Breath or bad taste
- ☐ Dental Problems
- ☐ Swollen throat or voice change
- ☐ Swollen glands in neck
- ☐ Ringing in the ears
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Sinus / Allergy problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other: ______________________
- ☐ *None in this Category*

Endocrine, Hematologic, and Lymphatic:

- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive Thirst or urination
- ☐ Cold Extremities
- ☐ Heat or Cold intolerance
- ☐ Change in hat or glove size
- ☐ Dry skin
- ☐ Glandular or hormone problem
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other: ______________________
- ☐ *None in this Category*

Skin and Breasts:

- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change of appearance of a mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other: ______________________
- ☐ *None in this Category*

Women Only:

Are you pregnant?

- ☐ **Yes - *Due Date*** ___/____/____
- ☐ **No - *Last Menstrual Period*** ___/____/____

- ☐ Infertility
- ☐ Painful or Irregular periods
- ☐ Vaginal Discharge
- ☐ Other: ______________________
- ☐ *None in this Category*

Pregnancies with Outcome & Date:

____

____

____

Comments: ____

____

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 to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature ____ Date__________________

Treating Doctor Signature ____ Date__________________

Patient No: ___________

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Dr. Stephen F. Kosterman
Chiropractor, PA
8511 Chapel Hill Rd.
Cary, NC 27513
Phone: 919-461-9779
Fax: 919-463-0715

Date: ______________________________
Name: ______________________________

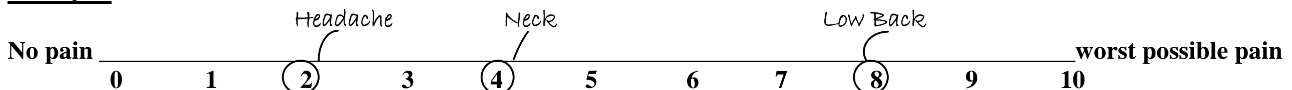
Quadruple Visual Analog Scale

Please read carefully

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

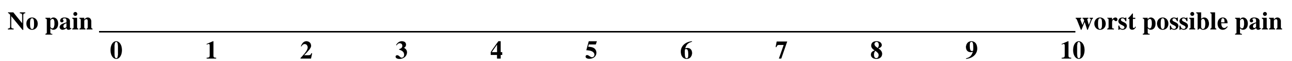
Example:



No pain ______________________________ **worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

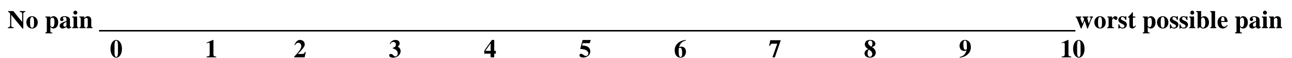
---

1. **What is your pain RIGHT NOW?**



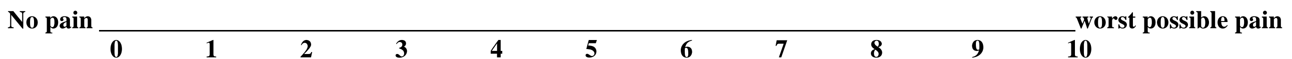
No pain ______________________________ **worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

2. **What is your TYPICAL or AVERAGE pain?**



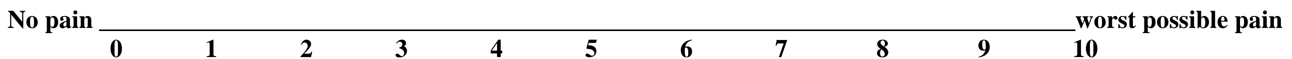
No pain ______________________________ **worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

3. **What is your pain level AT ITS BEST? (How close to "0" does your pain get at its best?)**



No pain ______________________________ **worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

4. **What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)**



No pain ______________________________ **worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

____

____

Patient Signature: ______________________________ Date: ______________________

(Internal use only) 1._____ + 2._____ + 4._____ = _____/ 3 x 10 = _____ (L<50>H)

Functional Rating Index

For use with Neck and/or Back Problems

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

1. Pain Intensity

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

Name: ____(Printed) ID#: ________________________ Group #: ____________________

Signature: ____ Date: _______________________ Total Score: __________________

Internal Use Only 1. Initial [______ / 40 = .______] 2. Follow up [______ / 40 = . ______] Clinical improvement [Total initial - Total follow-up / Total initial = ______
(Add all) (% total disability) (Add all) (% total disability) (% Clinical Improvement)

Kosterman Chiropractic
Consent, Assignment, and Agreement

Health care operations require you must read and sign this consent form stating you understand our office policies and how your records are handled. If you need a more detailed description of the privacy of your PATIENT HEALTH INFORMATION, our HIPPA NOTICE is available upon request from office staff.

1. I certify that all the information given in the provided intake questions and information is true and correct to the best of my knowledge. I give my consent to Dr. Stephen Kosterman the render treatments to myself/child as deemed necessary by the attending physician. I understand that I have the right to refuse such services at any time, and will be informed of any changes in treatment prior to their performance. A patient's written consent need only be obtained one time for subsequent care given to the patient in this office.

2. I understand that I am fully responsible for the payment of services rendered. I further understand that health and accident insurance policies are an arrangement between the carrier, and me and that I may be required to pay some or all of the fees charged because of services provided. I hereby assign benefits to be paid directly to the office of Dr. Stephen Kosterman by my third party payer (I.e., insurance company, attorney, etc.). My signature below shows agreement that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between me and the office of Dr. Stephen Kosterman. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. Any unpaid bills will be charged an interest of 18% APR, which is the patient's responsibility for services past rendered. Payment for services rendered at due at completion of the services, unless prior written agreement is agreed upon.

3. I give my consent to the office of Dr. Stephen Kosterman to perform x-rays as deemed necessary by the attending physician. I declare that to the best of my knowledge, (I am not pregnant, my child is not pregnant), nor are there any known complicating limitations which would forbid receiving x-0rays.

4. I authorize the office of Dr. Stephen Kosterman to send me e-mail, metered mail, phone texts and any other communication that is carried on to inform and notify of office hours and sudden changes in schedule.

5. The patient has the right to examine and obtain a 1-time copy of his or her own health records at any time and request corrections. A fee of $25 will be charged and paid in advance by the patient for forms needed to be filled out by the Doctor that fall outside the normal record keeping of this office. (I.e., AFLAC, Disability, Social Security, FMLA). The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to these restrictions.

6. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request had been presented.

7. HIPPA –for your securing right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to ensure these procedures are in place and current. We strive to ensure that your records are not readily available to those who request, want or do not need them. Patients have the right to file a complaint with our privacy official about any possible violations of these policies and procedures.

8. If the patient refuses to sign this consent for the purpose of treatment, payment of healthcare operations, the chiropractic office has the right to refrain from delivering care in which there is no understanding in which the services are to be delivered.

9. Clinical Summary Report (CCR): I understand that a clinical summary report is created after each visit or the purpose of HER and is available for my review. At this time, I am asking the office of Dr. Stephen Kosterman to save these reports electronically for me and not to print them out at each visit. I understand that upon request that these reports are available to be printed or emailed for me to review.

I have read and understand how my Patient Health Information will be used, understand informed consent and HIPPA, and agree to these policies and procedures.

Name of Patient: ____________________________________ **Date:** ____________

Patient/Guardian: ___________________________________