KORDONOWY
CHIROPRACTIC CENTER
Dr. Stuart Kordonowy
473 Hendersonville Rd., Suite C
Asheville, NC 28803
www.kordonowy.com
(828) 277-0903 FAX 277-2754

Confidential Patient Health Record

TODAY'S DATE:___/___/_____

Who can we thank for referring you to us?_____

First Name:_____ **Last Name:**_____ **DOB:** ___/___/_____ **Age:** _____
SSN:_____ *(some insurance companies ask for this when confirming your benefits)*
Address:_____
City:_____ **State:**_____ **Zip:**_____ **Email address:**_____

Primary Phone: (____)_____-_____ **Preferred Language:**_____

Gender: Male/Female **Marital Status:** Single Married Widowed Divorced Separated

Emergency Contact Name:_____ **Phone:**_____

Who is responsible for your bill? YOU and….(Circle one)
Myself ONLY Spouse Worker's Comp Auto Insurance Medicare Medicaid Other Health Insurance

Smoking Status (Circle one): Everyday Smoker/ Occasional Smoker/ Former Smoker/ Never Smoked
Smoking Start Date (Optional):_____

CMS requires providers to report both race and ethnicity
Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Height: _____ Weight: _____ Blood Pressure: _____/_____

Employment Information

Business Name:_____ **Occupation/Title:**_____
Phone: (___)___-_____
Job Description:_____

Doctor Information

Primary Doctor Name:_____ **Phone:** (___)___-_____
Do we have your permission to communicate with your doctor regarding your care in our office? **Y / N**
Patient Signature:_____

Unwanted Condition (Why are you here today?) _____
_____
_____

When did this condition BEGIN? ____/____/_____

Has it ever occurred before? Y / N When? _____

Do you SUFFER with ANY OTHER condition than which you are now consulting us?

_____

_____

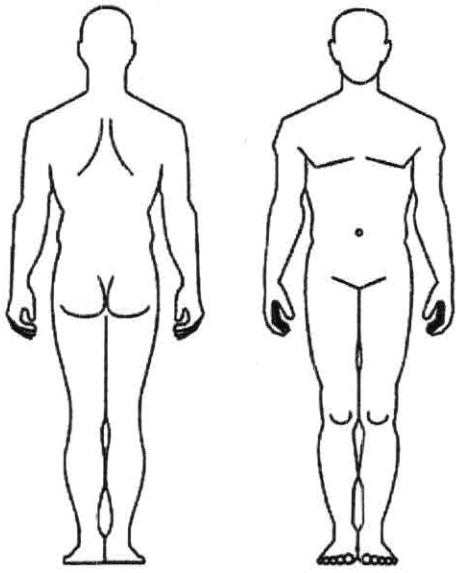
On a scale of 1-10, with 10 being agony and 1 being nearly no pain, what number best describes your pain:

at rest: **1 2 3 4 5 6 7 8 9 10**

with activity: **1 2 3 4 5 6 7 8 9 10**

Use the letters below to indicate the TYPE and LOCATION of your sensations right now.

Key: A=Ache B=Burning N=Numbness P=Pins & Needles S=Stabbing



Past Health History

Have you seen other doctors for THIS CONDITION? Y / N If yes, Who? (Name)_____
Type of Treatment:_____ **Was the treatment beneficial in resolving condition? Y / N**
Explain: _____

Have you received prior Chiropractic care? Y /N **Doctor's Name:**_____
Location: _____ **Date of last visit:**_____

Please list any and all health conditions, surgeries, and injuries (please write DATE(s) of occurrences):

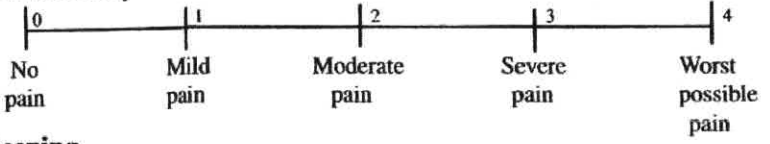
_____
_____
_____
_____
_____
_____

Functional Rating Index

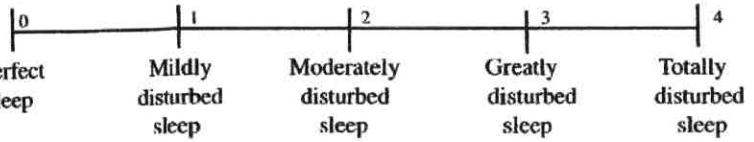
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or 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.**

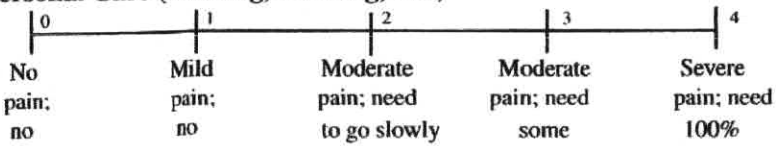
1. Pain Intensity



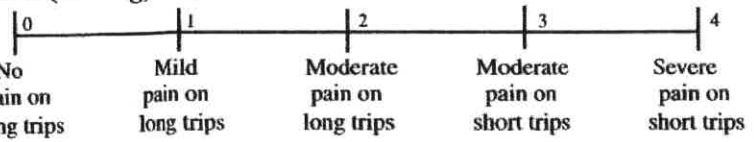
2. Sleeping



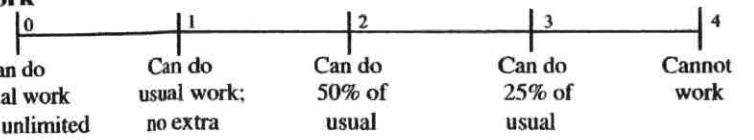
3. Personal Care (washing, dressing, etc.)



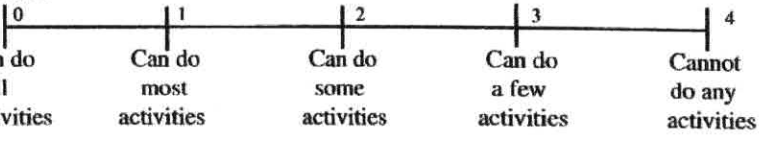
4. Travel (driving, etc.)



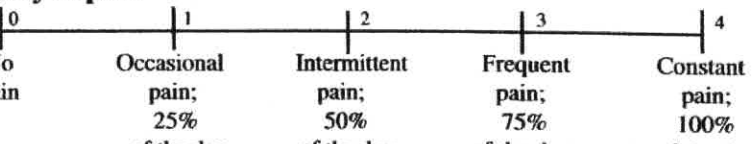
5. Work



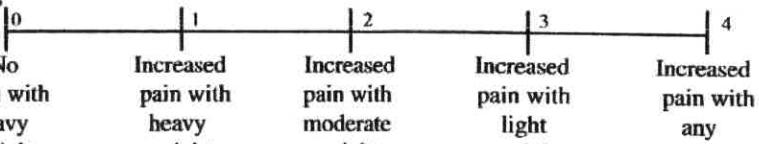
6. Recreation



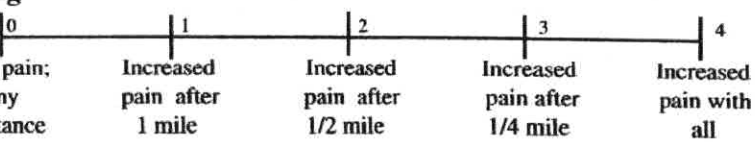
7. Frequency of pain



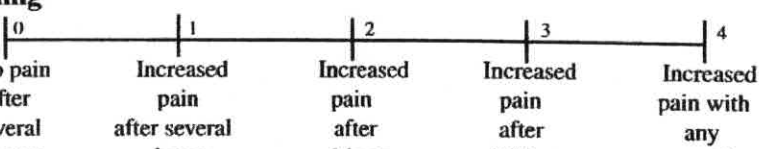
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

Informed Consent To Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various physical therapy modalities, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible:_____) by the chiropractic physicians and/or anyone working in this office authorized by the chiropractic physicians.

I further understand that such chiropractic services may be performed by Stuart Kordonowy, D.C., and I have had the opportunity to discuss with Dr. Kordonowy and/or with other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment, including, but not limited to, fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure for which the physician feels are in my best interests, at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ **Date:** _____

Patient's Signature: _____ **Date:** _____

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Patient Authorization

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed
The information covered by this authorization includes:
Appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you.

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:
Kordonowy Chiropractic Center
Name of Person Organization

Expiration Date of Authorization
This authorization is effective through _____ unless revoked or terminated by the patient or patient's personal representative.

Patient Rights

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

If you understand and agree with all of the above policies, please sign your name below.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date

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Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by KORDONOWY CHIROPRACTIC CENTER or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas
Describe and Notify private areas available upon request

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date