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 _____

Referido por _____

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

_____ _____
Fecha Firma Del Paciente

Hooper-Thurston
Elite Chiropractic
A Member of Elite Chiropractic Centers

Historial Clínico

Nombre _____ Fecha _____

Fecha De Nacimiento_____ Edad_____ Altura_____ Peso_____ Sexo M F

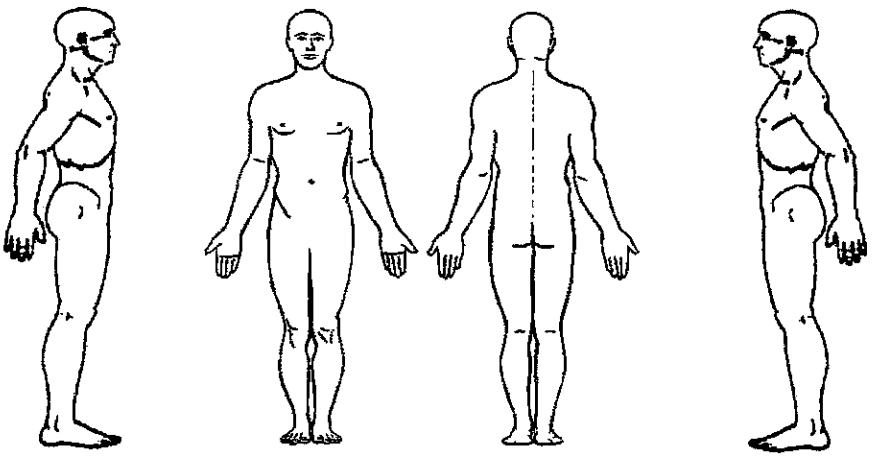
A recibido Usted cuidado Quiropráctico? Si o No Si, sí Cuando?_____

Queja principal:

la ubicación de la queja: _____

Diagrama para dolores:

indique donde siente
dolor / sintomas.



Cuando y como inicio la queja? _____

Por favor marque con un círculo la carecteristíca de la queja/dolor: dolor apagado, adolorido, agudo, punzante, ardiente, palpitante, persistente, otro _____

Esta queja/dolor iradia o viaja(dispara) a otra area de su cuerpo? Donde? _____

Tiene entumecimientos o hormigeos en su cuerpo? Donde? _____

Califique la intesidad de la queja/dolor: 0 1 2 3 4 5 6 7 8 9 10 (10 = peor dolor/queja posible)

Con que frecuencia la queja/dolor esta presente, cuanto tiempo dura? _____

Algo agrava la queja? _____

Algo ase que la queja mejore? _____

Previos tratamientos, medicaciónes, cirugia, examenes, o cuidados que a buscado para su queja:_____

_____

ACTUALMENTE experimenta usted **CUALQUIERA** de lo siguiente?

- ❒ Problemas Urinarios
- ❒ Calambres Musculares
- ❒ Cholesterol alto
- ❒ Infecciónes Recurrentes
- ❒ Problemas del Riñón
- ❒ Problemas de Visícula
- ❒ Toz crónica o Frecuente
- ❒ Otro_____
- ❒ Problemas Intestinales
- ❒ Problema con Coagulación de Sangre
- ❒ Perdida de Apetito Sexual
- ❒ Fatiga Fácilmente
- ❒ Depresión
- ❒ Perdida de Peso
- ❒ Mareos o Vertigo
- ❒ Sudor Nocturno
- ❒ Salpullido en la Piel
- ❒ Problemas de Próstata
- ❒ Problemas Estomacales
- ❒ Ansiedad
- ❒ SIDA/VIH
- ❒ Desmayos
- ❒ Fiebre
- ❒ Sensibilidad al Frio
- ❒ Calambres Musculares
- ❒ Migrañas
- ❒ Irregularidad Menstrual
- ❒ Hepatitis
- ❒ Dolor de Pecho

Fecha de su ultimo examen físico: _____

Firma del Doctor_____,D.C. Fecha _____

Historial médico del pasado:

A tenido Usted **ALGUNO** de los siguientes **EN EL PASADO?**

❒ Lesión de cabeza	❒ Lesión de Columna	❒ Osteoporosis	❒ Problemas de Espalda
❒ Problemas Respiratorios	❒ Trauma	❒ Epilepsia	❒ Enfermedad de Parkinson
❒ Esclerosis Múltiple	❒ Distrofia Muscular	❒ Derrame Cerebral	❒ Problemas del Corazon
❒ Presión Arterial Baja	❒ Diabetes	❒ Presión Arterial Alta	❒ Cancer
❒ Problemas de Tiroide	❒ Problema con Coagulación de Sangre		❒ Distrofia Muscular
❒ Implante Quirúrgico	❒ Polio	❒ Enfermedad Vascular	❒ Otro_____

Explique:_____

Historial Médico:

Es actualmente bajo cuidado activo por otro médico? No Si _____

Por favor liste a su médico primario del cuidado/proveedor de asistencia médica?_____

Complete lo siguiente:

Alergias:_____

Medicaciónes:

Nombre	Razón por que se las toma
_____	_____
_____	_____
_____	_____

Cirugías:

Fecha	Tipo de cirigía
_____	_____
_____	_____

Ha tenido usted cualquier radiografía, CTs, IRMs u otra prueba especial en el último año?_____

Ha tenido usted algun implante quirúrgico (marcapasos, tornillos, alfileres, clips)?_____

Toma actualmente usted medicamento para afinar la sangre (como Plavix, Coumadin, o Warfarin)? No Si

Historial Social:

Uso de tabaco: Nunca Cigarros mastica Otro
Cuanto al dia:_____ Cuantos años:_____ Cuando lo dejo_____

Uso de Cafeina: Nunca Ocasional A menudo Fuente: refresco Café Té Bebida energetica Otro
Uso de Alcohol: Nunca Ocasional A menudo Bebidas/Semana:_____
Ejercicio: Nunca Ocasional A menudo Tipo de ejercicio:_____ Dias/Semana:_____

Historial de Familia:

especifique ésos que aplican sólo a miembros de familia **MÁS CERCANOS:** (abuelos, padres, hermanos)

artritis_____ enfermedad cardíaca_____ Hipertensión _____

Derrame Cerebral _____ Cancer_____ Enfermedad neurológica _____

Diabetes _____ Otro_____ Otro _____

Firma del Doctor_____,D.C. Fecha _____

Historial de su Empleo:

Qué hace usted/en que trabaja? _____

Qué tipo de actividades hace en su trabajo? _____

Historial De Actividades Recreacionales:

Qué hace para divertirse/Actividades Recreacionales? _____

Solo Para Mujeres:

Esta embarazada ahora? Si No

Cuantas semanas/meses? _____ fecha de nacimiento aproximado _____

embarazos/alumbramientos/abortos pasados? _____

Esta Usted tratando de quedar embarazada? Si No

En que fecha tuvo su ultimo periodo menstrual? _____

Esta Usted pos-menopáusica? Si No

Esta tomando píldoras anticonceptivas? Si o No

Esta usted en medicamentos de hormonas sustitivas? Si No

Revisión y Consentimiento

He leído la información posterior y certifico que es verdad y correcta a lo mejor de mi sabiduria, y por lo presente autorizo a esta oficina de Quiropráctico para proveerme cuidado Quiropráctico, de acuerdo con las leyes de este estado. Yo entiendo que es mi responsabilidad traer atención al medico CUALQUIER nueva información con respecto a mi salud y bien estar o algun cambio en mi estado de salud que sea pertinente al manejo de mi caso.

Como cualquier procedimiento del cuidado de salud, hay ciertas complicasiónes que pueden surjir durante la terapia y manipulación quiropráctica. Algunos pacientes sentiran rigidez y dolor muscular despues de los primeros días del tratamiento. El doctor hara todo lo razonablemente posible durante le examinación para investigar caulquier contraindicaciones del cuidado; sin embargo si Usted tiene una condición que de otro modo no vendría a nuestra atención, es su responsabilidad informarnosla.

Firma del paciente _____ Fecha _____

Firma de Padres o Tutor Legal _____ Fecha _____

Firma del Doctor _____,D.C. Fecha _____

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 _____, _____.

_____
Patient or Guardian Signature

Patient's Name: _____

Address: _____

_____

Birth Date: _____

Records from: _____

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

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.

****

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.

Hooper-Thurston
Elite Chiropractic
A Member of Elite Chiropractic Centers

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.

****

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.**

Print Name	**Signature**	**Date**