Timothy M. Kosterman, D.C.

KOSTERMAN
CHIROPRACTIC CENTER

"Good Health for Life"

401 Cooper Drive
Clinton, North Carolina 28328
(910) 592-2250 • Fax (910) 592-6149
www.spinaldoc.org

OFFICE PROCEDURES

You have come to our office for help with your current symptoms, and we are looking forward to the opportunity to be of service. Please review the following information, so that you know what to expect on your first visit and follow-up Report of Findings visit.

YOUR FIRST VISIT

On your first visit, you will consult with Dr. Kosterman about your currect symptoms. He will assess your history, and condition to determine if you are experiencing any of the common signs of potential spinal "subluxations" (Mis-alignments, fixations "jamming" of the vertebrae in the spine that can cause nerve interference.) If this is the case, you will receive a full orthopedic, neurological examination and x-rays if needed. This allows Dr. Kosterman to better determine your present condition and state of spinal health. Dr. Kosterman will need some time to assess your examination/x-ray findings, and you will be asked to return for a full report, later that same day, or the following day. He will gladly provide you with suggestions to ease any discomfort until the report visit.

YOUR REPORT OF FINDINGS VISIT

Dr. Kosterman will fully review your examination/x-ray findings with you, and let you know:

- What is **causing your pain** and/or symptoms
- If he **can help you**
- What **plan of treatment** is best for your condition
- Approximately **how long it will take**
- What is **needed from you** to attain the best results

If the Doctor can accept your condition with chiropractic care, and after your report, you will be ready to begin your first treatment.

YOUR FINANCIAL REPORT

Before your treatment, you will sit down with our Insurance & Accounts CA She will be able to provide you with an estimate of your potential care costs, and will gladly discuss your insurance coverage, and all of the options available to you for payment.

IF AT ANY TIME, YOU SHOULD HAVE ANY QUESTIONS OR NEED ASSISTANCE, PLEASE DO NOT HESITATE TO ASK US. WELCOME TO OUR OFFICE!

Dr. Tim Kosterman

KOSTERMAN CHIROPRACTIC CENTER

Patient Health History

Signature of Patient _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____**Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____**Secondary Phone** _____

Mobile Phone _____

****Home email** _____ ****Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth [/ /] **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the Chosen question: _____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1)		**5)**	
2)		**6)**	
3)		**7)**	
4)		**8)**	

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____

Spouse Data

Is your spouse a patient in the clinic? ☐ Yes ☐ No

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Home Phone: (_____)_____-_____ **Work Phone:** (_____)_____-_____

Employer Data

Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact

Contact Name: _____

Contact Phone: (_____) _____-_____

Is it okay to call you at work?

❑ Yes ❑ No

How did you hear about our clinic? Or who referred you?

❑ Family member	❑ Attorney	❑ Internet web site	❑ Health class
❑ Friend	❑ Yellow Pages	❑ Billboard	❑ Brochure
❑ Physician	❑ Newspaper ad	❑ TV Commercial	❑ Direct mail ad
❑ Employer	❑ Sign on building	❑ Radio	❑ Other

If you selected 'Yellow Pages' please indicate which Yellow Pages:

_____ _____ _____ _____

If you selected 'family member', 'friend', or 'physician' please enter their name below:

_____

If you selected 'other' please describe

_____

Medical Conditions:

❑ Arthritis	❑ Cancer	❑ Diabetes	❑ Heart Disease
❑ Hypertension	❑ Psychiatric Illness	❑ Skin Disorder	❑ Stroke

Surgeries:

❑ Appendectomy	❑ Cardiovascular procedure	❑ Cervical disc procedure	❑ Hysterectomy
❑ Joint replacement	❑ Laminectomies	❑ Radical prostatectomy	❑ Transuretheral prostate surgery

Allergies:

- ❑ Eggs
- ❑ Fish and Shellfish
- ❑ Milk or Lactose
- ❑ Peanut
- ❑ Soy
- ❑ Sulfites
- ❑ Wheat/Gluten

Social History:

- ❑ Caffeine used occasionally
- ❑ Caffeine used often
- ❑ Chew tobacco occasionally
- ❑ Chew tobacco often
- ❑ Drink alcohol occasionally
- ❑ Drink alcohol often
- ❑ Exercise not at all
- ❑ Exercise occasionally
- ❑ Exercise often
- ❑ Experience stress occasionall
- ❑ Experience stress often
- ❑ Smoke 1 pack or less per day
- ❑ Smoke more than 1 pack a day
- ❑ Wear seat belts always
- ❑ Wear seat belts never
- ❑ Wear seatbelts usually

Family History:

- ❑ Arthritis (parent)
- ❑ Arthritis (sibling)
- ❑ Cancer (parent)
- ❑ Cancer (sibling)
- ❑ Cholesterol (parent)
- ❑ Cholesterol (sibling)
- ❑ Diabetes (parent)
- ❑ Diabetes (sibling)
- ❑ Heart problems (parent)
- ❑ Heart problems (sibling)
- ❑ High blood pressure (parent)
- ❑ High blood pressure (sibling)
- ❑ Psychiatric (parent)
- ❑ Psychiatric (sibling)
- ❑ Stroke (parent)
- ❑ Stroke (sibling)
- ❑ Thyroid (parent)
- ❑ Thyroid (sibling)

Substance Use:

- ❑ Alcohol (past)
- ❑ Alcohol (present)
- ❑ Amphetamines (past)
- ❑ Amphetamines (present)
- ❑ Barbiturates (past)
- ❑ Barbiturates (present)
- ❑ Cocaine (past)
- ❑ Cocaine (present)
- ❑ Crystal Meth (past)
- ❑ Crystal Meth (present)
- ❑ Heroine (past)
- ❑ Heroine (Present)
- ❑ Marijuana (past)
- ❑ Marijuana (present)

Male Children:

- ❑ Under 6 years
- ❑ Under 10 years
- ❑ Under 19 years

Female Children:

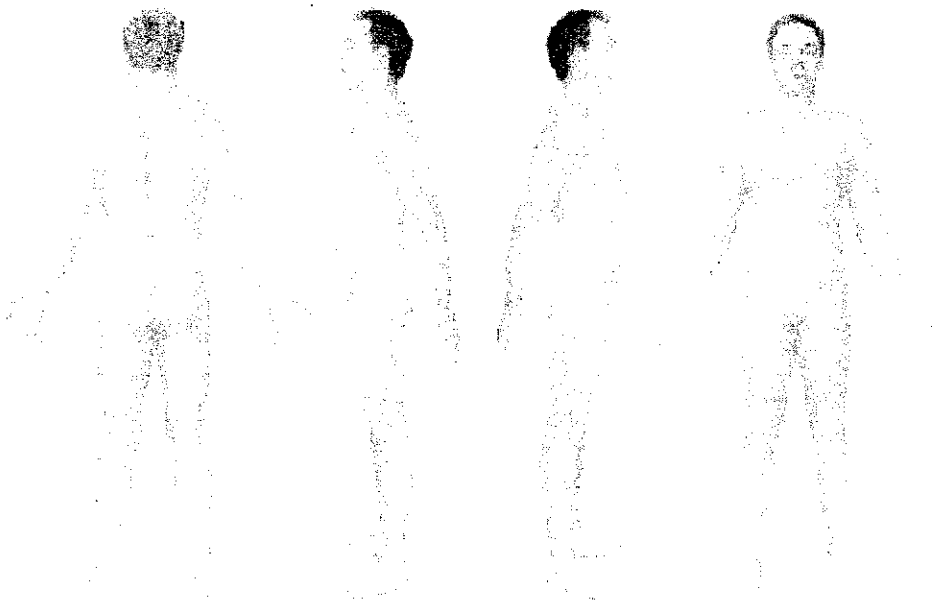
- ❑ Under 6 years
- ❑ Under 10 years
- ❑ Under 19 years

Occupational Activities:

- ❑ Administration
- ❑ Business owner
- ❑ Clerical/secretarial
- ❑ Computer user
- ❑ Construction
- ❑ Daycare/childcare
- ❑ Executive/legal
- ❑ Food service industry
- ❑ Health care
- ❑ Heavy equipment operator
- ❑ Heavy manual labor
- ❑ Home services
- ❑ Household
- ❑ Light manual labor
- ❑ Manufacturing
- ❑ Medium manual labor

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

 # = Numbness **X = Burning** **/ = Stabbing** **0 = Pins & Needles** **+ = Dull Ache**



Describe your symptoms:_____

_____

When did your symptoms start? **Month**_____ **Day**_____ **Year**_____

How did your symptoms begin?_____

_____

How often do you experience your symptoms?

- ❑ Constantly (76-100% of the day)
- ❑ Frequently (51-75% of the day)
- ❑ Occasionally (26-50% of the day)
- ❑ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- ❑ Sharp
- ❑ Dull ache
- ❑ Numb
- ❑ Shooting
- ❑ Burning
- ❑ Tingling
- ❑ Stabbing

How are your symptoms changing?

- ❑ Getting better
- ❑ Not changing
- ❑ Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

- ❑ 0 None
- ❑ 1
- ❑ 2
- ❑ 3
- ❑ 4
- ❑ 5
- ❑ 6
- ❑ 7
- ❑ 8
- ❑ 9
- ❑ 10 Unbearable

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):

- ❑ Not at all
- ❑ A little bit
- ❑ Moderately
- ❑ Quite a bit
- ❑ Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

- ❑ All of the time
- ❑ Most of the time
- ❑ Some of the time
- ❑ A little of the time
- ❑ None of the time

In general, would you say your overall health right now is....

- ❑ Excellent
- ❑ Very good
- ❑ Good
- ❑ Fair
- ❑ Poor

Who have you seen for your symptoms:

- ❑ No one
- ❑ Other Chiropractor
- ❑ Medical Doctor
- ❑ Physical Therapist
- ❑ Other

What treatment did you receive for your symptoms?

- ❑ Adjustments
- ❑ Physical Therapy
- ❑ Medication
- ❑ Surgery
- ❑ Other

When did you receive this treatment?

- ❑ In the last month
- ❑ 2 – 3 months ago
- ❑ 3 – 6 months ago
- ❑ 6 months to 1 year ago
- ❑ 1 – 2 years ago
- ❑ 2 – 5 years ago
- ❑ 5 – 10 years ago

What tests have you had for your symptoms?

- ❑ X-rays
- ❑ MRI
- ❑ CT Scan
- ❑ Other

When were these tests done?

- ❑ In the last month
- ❑ 2 – 3 months ago
- ❑ 3 – 6 months ago
- ❑ 6 months to 1 year ago
- ❑ 1 - 2 years ago
- ❑ 2 – 5 years ago
- ❑ 5 – 10 years ago

Have you had similar symptoms in the past?

- ❑ Yes
- ❑ No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

❑ This Office ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist
❑ Other

What is your occupation?

❑ Professional/Executive ❑ White Collar/Secretarial ❑ Tradesperson ❑ Laborer
❑ Homemaker ❑ Full-time Student ❑ Retired ❑ Other

If you are not retired, a homemaker or a student, what is your work status?

❑ Full-time ❑ Part-time ❑ Self-employed ❑ Unemployed
❑ Off work ❑ Other

Review of Systems:

Have you had trouble with any of the following:

Cardiovascular: No ____

	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

Genitourinary: No ____

	Present	Past	No
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in urine			
Kidney Stone			

Hematologic/lymphatic: No ____

	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

Neurologic: No ____

	Present	Past	No
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			

Respiratory: No ____

	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

Ears/Nose/Throat: No ____

	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			

Eyes: No ____

	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

Integumentary: No ____

	Present	Past	No
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

Psychiatric: No ____

	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

Constitutional: No ____

	Present	Past	No
Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

Allergic/Immunologic: No ____

	Present	Past	No
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

Gastrointestinal: No ____

	Present	Past	No
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

Musculoskeletal: No ____

	Present	Past	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

Endocrine: No ____

	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			

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AUTHORIZATION TO RELEASE INFORMATION AND ASSIGMENT OF BENEFITS

DATE:

To: INSURANCE CARRIER___ ATTORNEY___ PHYSICIAN___ OTHER___

Name: _____

Address: _____

_____

Phone: _____

From: DR. TIM KOSTERMAN

401 Cooper Drive
Clinton, NC 28328

I, the undersigned patient, authorize the above named doctor to release and/or obtain any information he deems appropriate and concerning my health condition to/from any insurance company, attorney, or adjuster in order to process any claim for reimbursement of any/all services rendered.

I, also authorize said doctor to release and/or obtain any information he deems appropriate concerning my health condition to/from any physician or medical associate that he deems necessary for the most optimum outcome of my care.

I authorize and assign any responsible insurance companies, attorney, or other guarantor to make any/all payments directly to said doctor at his office address shown above.

This Authorization and Assignment will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original.

PATIENT'S NAME:_____ **DATE:**_____

SIGNATURE: _____

WITNESS: _____

Timothy M. Kosterman, D.C.

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AUTHORIZATION TO OBTAIN INFORMATION

DATE: _____

To: _____

_____

_____

_____

From: Dr. Tim Kosterman

401 Cooper Drive
Clinton, NC 28328

I, the undersigned patient, authorization Kosterman Chiropractic Center to obtain acute care records they deem necessary concerning my health condition from your facility for the most optimum outcome of my care.

This Authorization will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original.

PATIENT'S NAME: _____

SIGNATURE: _____ **DATE:** _____

WITNESS: _____

Timothy M. Kosterman, D.C.

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I HAVE NOTIFIED KOSTERMAN CHIROPRACTIC CENTER OF MY CURRENT MEDICAL INSURANCE AND MAILING ADDRESS.

MY PREFERRED CONTACT PHONE NUMBER IS _____

MY MEDICAL INFORMATION MAY BE SHARE WITH _____ _____(NAME/RELATIONSHIP).

I AM AWARE OF THE NOTICE OF PRIVACY PRACTICES OF KOSTERMAN CHIROPRACTIC CENTER LOCATED IN THE PATIENT WAITING ROOM.

I WILL ALLOW THE FOLLOWING PEOPLE TO INQUIRE ABOUT MY APPOINTMENT TIMES AND THEY CAN BE GIVEN SUCH INFORMATION BY EMPLOYEES OF KOSTERMAN CHIROPRACTIC CENTER.

1. _____

2. _____

3. _____

4. _____

PATIENT/GUARDIAN SIGNATURE _____**DATE**_____

PRINT NAME _____

Timothy M. Kosterman, D.C.

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Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Kosterman Chiropractic Center.

I understand that the Notice describes the uses and disclosures of my protected health information by Kosterman Chiropractic Center and informs me of my rights with respect to my protected health information.

Patient's Signature or that of Legal Representative

Printed Name of Patient or that of Legal Representative

Today's Date

If Legal Representative, Indicate Relationship

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

Employee Name

Today's Date