Family Holistic Health Care of Fairfield

Douglas J. Koch D.C., C.C.N., F.I.A.M.A.. • 1100 Kings Highway East • Fairfield, CT 06825 • 203.576.1993

PATIENT INFORMATION

Name: _____ Age _____ Date of Birth: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): _____ Sex: ☐ F ☐ M Phone (Cell): _____

Occupation: _____ Phone (Work): _____

Employer: _____ Marital Status: ☐S ☐M ☐D ☐W # Children: _____

Insured's Name: _____ Insured's Date of Birth: _____

Insured's Phone: _____ Insurance Company: _____

Spouse's Name: _____ Spouse's Occupation: _____

Spouse's Employer: _____ Past Chiropractic Care: ☐Yes ☐No When? _____

Referred by: _____ Results: _____

Chief Complaint: 1._____ Duration (How long): _____ Previous Episodes _____

List Current 2. _____ Duration (How long): _____ Previous Episodes _____

Problems 3. _____ Duration (How long): _____ Previous Episodes _____

Is the condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes & goes

What activities aggravate your condition? _____

Are your present problems due to an injury? ☐ No ☐ Yes ☐ On Job ☐ Auto Accident ☐ Personal Injury ☐ Other: _____

Drugs you now take: ☐ Nerve pills ☐ Painkillers ☐ Muscle relaxers ☐ Blood pressure pills ☐ Insulin

☐ Birth control pills ☐ Vitamin supplements ☐ Others _____

Do you wear: ☐ Heel lifts ☐ Orthotics ☐ Arch supports Any other conditions you suffer from at this time? _____

Name and address of primary care physician _____

Please mark area & type of pain on the drawings using the codes listed below

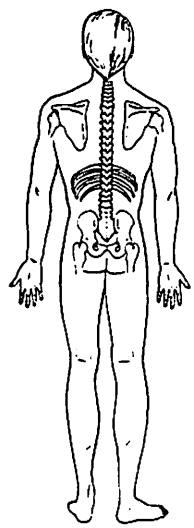
Please mark the intensity of your pain today

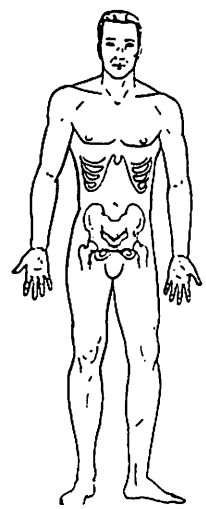
1= NO PAIN

10= MOST INTENSE EVER FELT

Example 1—2—3—4—5—❻—7—8—9—10—

1. —1—2—3—4—5—6—7—8—9—10—
2. —1—2—3—4—5—6—7—8—9—10—
3. —1—2—3—4—5—6—7—8—9—10—

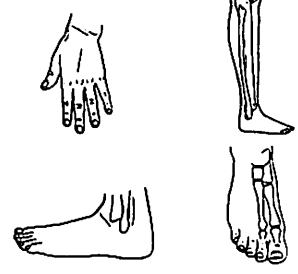




N = Numbness P = Pain

T = Tingling A = Ache

S = Soreness ST = Stiffness



HABITS		EXERCISE	FAMILY HISTORY				
				Diabetes	Heart	Cancer	Back
☐ Smoking	Packs/Day:_____	☐ None					
☐ Alcohol	Drinks/Day:_____	☐ Moderate	Mother	☐	☐	☐	☐
☐ Coffee/Soda	Cups/Day:_____	☐ Daily	Father	☐	☐	☐	☐
☐ Water	Cups/Day:_____	Type: _____	Siblings, # of____	☐	☐	☐	☐

PAST HEALTH HISTORY

*Please be as complete as possible. All information is **strictly** confidential.*

List surgical operations and years _____

Have you ever had a(n): ☐ Auto Accident ☐ Sports Injury ☐ Household Accident ☐ Work Injury ☐ Personal Injury

Have you ever been hospitalized? _____ Have you broken any bones? _____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

☐ Appendicitis	☐ Anemia	☐ Heart Disease	☐ Arthritis
☐ Pneumonia	☐ Measles	☐ Goiter	☐ Epilepsy
☐ Rheumatic Fever	☐ Mumps	☐ Influenza	☐ Mental Disorder
☐ Polio	☐ Chicken Pox	☐ Pleurisy	☐ Lumbago
☐ Tuberculosis	☐ Diabetes	☐ Alcoholism	☐ Eczema
☐ Whooping Cough	☐ Cancer	☐ Venereal Disease	☐ HIV Positive

Please check the correct box for each choice below. Check at least one box for each sign or symptom listed.

N = Never O = Occasional F = Frequent

N O F	GENERAL SYMPTOMS	N O F	GASTRO-INTESTINAL	N O F	EYE/EAR/NOSE/THROAT	N O F	RESPIRATORY
☐ ☐ ☐	Allergy (what)_____	☐ ☐ ☐	Belching or Gas	☐ ☐ ☐	Asthma	☐ ☐ ☐	Chest Pain
	_____	☐ ☐ ☐	Colon Trouble	☐ ☐ ☐	Deafness	☐ ☐ ☐	Chronic Cough
☐ ☐ ☐	Convulsions	☐ ☐ ☐	Constipation	☐ ☐ ☐	Earache	☐ ☐ ☐	Difficulty Breathing
☐ ☐ ☐	Dizziness	☐ ☐ ☐	Diarrhea	☐ ☐ ☐	Ear Discharge	☐ ☐ ☐	Spitting Blood
☐ ☐ ☐	Fainting	☐ ☐ ☐	Excessive Hunger	☐ ☐ ☐	Ear Noises	☐ ☐ ☐	Spitting Phlegm
☐ ☐ ☐	Fatigue	☐ ☐ ☐	Gall Bladder Trouble	☐ ☐ ☐	Enlarged Thyroid		GENITO-URINARY
☐ ☐ ☐	Fever	☐ ☐ ☐	Hemorrhoids (piles)	☐ ☐ ☐	Frequent Colds	☐ ☐ ☐	Bed Wetting
☐ ☐ ☐	Headache	☐ ☐ ☐	Jaundice	☐ ☐ ☐	Hay Fever	☐ ☐ ☐	Blood in Urine
☐ ☐ ☐	Loss of Sleep	☐ ☐ ☐	Liver trouble	☐ ☐ ☐	Hoarseness	☐ ☐ ☐	Frequent Urination
☐ ☐ ☐	Loss of Weight	☐ ☐ ☐	Nausea	☐ ☐ ☐	Nasal Obstruction	☐ ☐ ☐	Inability toControl Urine
☐ ☐ ☐	Nervousness	☐ ☐ ☐	Pain over Stomach	☐ ☐ ☐	Nose Bleeds	☐ ☐ ☐	Kidney Infection
☐ ☐ ☐	Night Sweats	☐ ☐ ☐	Poor Appetite	☐ ☐ ☐	Poor Vision	☐ ☐ ☐	Painful Urination
☐ ☐ ☐	Numbness or pain in	☐ ☐ ☐	Poor Digestion	☐ ☐ ☐	Sinusitis	☐ ☐ ☐	Prostate Trouble
	arms/legs/hands	☐ ☐ ☐	Vomiting	☐ ☐ ☐	Sore Throats		FOR WOMEN ONLY
☐ ☐ ☐	Wheezing		CARDIO-VASCULAR		SKIN OR ALLERGIES	☐ ☐ ☐	Cramps or Backache
	MUSCLES & JOINTS	☐ ☐ ☐	High Blood Pressure	☐ ☐ ☐	Boils	☐ ☐ ☐	Excessive Flow
☐ ☐ ☐	Backache	☐ ☐ ☐	Low Blood Pressure	☐ ☐ ☐	Bruising Easily	☐ ☐ ☐	Hot Flashes
☐ ☐ ☐	Foot trouble	☐ ☐ ☐	Pain over Heart	☐ ☐ ☐	Dryness	☐ ☐ ☐	Irregular Cycle
☐ ☐ ☐	Pain between Shoulders	☐ ☐ ☐	Poor Circulation	☐ ☐ ☐	Eczema	☐ ☐ ☐	Miscarraige
☐ ☐ ☐	Painful Tail Bone	☐ ☐ ☐	Rapid Heart	☐ ☐ ☐	Hives or Allergies	☐ ☐ ☐	Painful Periods
☐ ☐ ☐	Stiff Neck	☐ ☐ ☐	Slow Heart	☐ ☐ ☐	Itching	☐ ☐ ☐	Vaginal Discharge
☐ ☐ ☐	Spinal Curvature	☐ ☐ ☐	Swelling Ankles	☐ ☐ ☐	Sensitive Skin	☐Yes ☐No	Pregnant at this time?
☐ ☐ ☐	Swollen Joints	☐ ☐ ☐	Varicose Veins	☐ ☐ ☐	Skin Eruptions	Last Pap_____	By Whom_____

I understand and agree that health and accident policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Douglas J. Koch, D.C. will prepare any necessary report and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Douglas J. Koch, D.C. will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.
I hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care and I give authority for these procedures to be performed.

Patient's Signature: _____ Date _____

Guardian or Spouse's Signature: _____

FAMILY HOLISTIC HEALTH CARE AND NEUROBIOFEEDBACK SERVICES
1100 Kings Highway East Suite 1C
Fairfield, CT 06825

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent (see binder on Waiting Room book rack). The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also for the practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following: that appointment reminders will be used by the Practice. A separate form will be used to allow me to choose email and/or text notifications. I have the option to deny either or both.
4. The Practice may use/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary, for the Practice to conduct its specific health care operations.
5. I understand that the Practice may want to use my PHI to communicate with the CCA (Connecticut Chiropractic Association) to receive their assistance if necessary to resolve a dispute with an insurance company when a claim is denied or reduced. It has been explained to me that I can restrict the use of my PHI now or at a later date for the above expressed purposes.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to what the Practice has already taken action on in reliance on this consent.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (Printed) Signature of Individual

Date Signed _____/_____/_____

*If patient is a minor or unable to consent, parent/guardian/health proxy should complete below.

_____ _____

Signature of Legal Representative Relationship

Family Holistic Health Care

1100 Kings Highway East

Fairfield, CT 06825

203 576-1993

In order that we can send you statements, visit summaries (if requested), and other correspondences such as visit reminders, please provide us with your email address and cell phone information.

Email Address: _____

Cell Phone Number: _____

Cell Phone Carrier:

ATT _____ Verizon _____

Sprint _____ T Mobile _____

Cingular _____ Boost _____

Metro _____ US Cell _____

Virgin _____

I would like to receive appointment reminders via:

Email _____

Text _____

Email and Text _____

Print Name: _____

Signature: _____

Date: _____