KINSTON CHIROPRACTIC PA
1100 Hardee Rd Ste 114
Kinston NC 28504
Dr. Gary L. Wojeski

ACCT # _____

PHONE (252) 523-2225 **FAX (252) 523-9919**

WELCOME

Dr. Wojeski and the staff of Kinston Chiropractic would like to welcome you to our office. We are determined to provide you with the best care possible. Please feel free to ask questions and let us know if we can assist you in any way.

Today's Date _____ **Gender:** ☐ Male ☐ Female **Title:** ☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss ☐ Dr. ☐ Rev

First Name _____ **Name You Liked to Be Called** _____

Last Name _____ **Middle Name** _____ **Suffix** Jr. II III IV

_____ _____ ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widow** ☐**Separated**
Birth Date (MM/DD/YYYY) **Social Security #**

Address _____

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

Primary Phone: (**)** _____ **Cell Phone: (** **)** _____

E Mail: _____@_____ **E Mail:** _____ @ _____

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

_____ _____ _____ _____
Emergency Contact **Relationship** **Phone #** **Cell #**

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE: _____

Employment Status: ☐ **Unemployed** ☐ **Full Time** ☐ **Part Time** ☐ **Self Employed** ☐ **Student** ☐ **Retired** ☐ **Disabled**

_____ _____ _____
OCCUPATION **EMPLOYER** **WORK PHONE**

_____ _____ _____ _____
ADDRESS **CITY** **STATE** **ZIP CODE**

_____
JOB DESCRIPTION

_____ _____ _____ _____
SPOUSE OCCUPATION **DOB** **EMPLOYER** **WORK PHONE**

HOW DO YOU PREFER TO BE CONTACTED? ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

KINSTON CHIROPRACTIC PA Dr. Gary L. Wojeski NAME _____ ACCT # _____

Please provide a ONE verification answer so that we may identify you if we have to share your PHI over the phone?

☐ What is the name of your pet? ☐ In what city were you born? ☐ In what city was your high school?

☐ In what city were you married? ☐ What is your mother's maiden name? ☐ Where were you on 911?

☐ What is your favorite car?

Verification Answer to the Chosen question: (must be at least six characters) _____

RACE (Check One)

☐ **White** ☐ **Black/African American** ☐ **Hispanic** ☐ **American Indian/Alaskan Native**

☐ **Asian** ☐ **Asian Indian** ☐ **Chinese** ☐ **Filipino**

☐ **Japanese** ☐ **Korean** ☐ **Vietnamese** ☐ **Native Hawaiian or Pacific Island**

☐ **Samoan** ☐ **Guamanian of Chamorro** ☐ **Middle Eastern**

PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Other _____

MULTI-RACIAL: (Check one) ☐ Yes ☐ No ☐ Unknown

ETHNICITY: (Check One) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I Choose Not To Specify

Who is responsible for your bill? ☐ Self ☐ Spouse ☐ Health Ins. ☐ Worker's Comp ☐ Auto Insurance
Have you filed an injury report with your employer? ☐ Yes ☐ No Date: ____/____/____ Time: _____am / pm

INSURANCE INFORMATION

_____ _____
PRIMARY INSURANCE COMPANY **SECONDARY INSURANCE COMPANY**

_____ _____
NAME OF INSURED RELATIONSHIP TO PATIENT **NAME OF INSURED RELATIONSHIP TO PATIENT**

_____/_____/_____ **Insured's Date of Birth** _____/_____/_____ **Insured's Date of Birth**

_____ _____
POLICY NUMBER **POLICY NUMBER**

_____ **(_____) _____ - _____**
PRIMARY CARE DOCTOR **PHONE #**

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?
q 0 q 1 q 2 q 3 q 4 q 5 q 6 q 7 q 8 q 9 q 10

No interest ***Very Interested***

KINSTON CHIROPRACTIC PA Dr. Gary L. Wojeski NAME _____ ACCT # _____

HEALTH HISTORY

List Current Medications

	Medication	Reason	Dosage	Frequency
1.				
2.				
3.				
4.				
5.				

IF THERE ARE NO CURRENT MEDICATIONS, CHECK HERE: ☐

Medication Allergies

	Medication Allergy	Reaction	Date Began
1.			
2.			
3.			

IF THERE ARE NO KNOWN MEDICATION ALLERGIES, CHECK HERE: ☐

Other Allergies (Non Medication): (Check all that apply) ☐ Eggs ☐ Soy ☐ Shellfish ☐ Milk/Lactose ☐ Peanuts ☐ Sulfites ☐ Wheat/Gluten ☐ Latex ☐ Bee Stings ☐ Other _____

IF THERE ARE NO KNOWN OTHER ALLERGIES, CHECK HERE: ☐

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

Has any doctor diagnosed you with Hypertension (High Blood Pressure) presently? ☐ Yes ☐ No

If yes, what was your LAST reading : _____

Has any doctor diagnosed you with Diabetes presently? ☐ Yes ☐ No

If yes, what kind? ☐ Type I ☐ Type II

If you answered "yes" to Diabetes, was your blood lab-work test for hemoglobin A1C > 9.0%?

☐ Yes ☐ No ☐ Not Sure

May we obtain a copy of your A1C? **☐ Yes ☐ No** ***List managing doctor:*** _____

KINSTON CHIROPRACTIC PA Dr. Gary L. Wojeski NAME _____ ACCT # _____

HAVE YOU HAD ANY ACCIDENTS OR INJURIES (Include Auto Accidents, Recreational, Sports, Falls, etc.)? ☐ Yes ☐ No

(If you answered YES! Please list dates and give a brief description of each accident or injury)

DATE ____/____/_____ _____ DATE ____/____/_____ _____
DATE ____/____/_____ _____ DATE ____/____/_____ _____
DATE ____/____/_____ _____ DATE ____/____/_____ _____

Have you ever been knocked unconscious? Describe cause: _____
Had a fractured bone? Where? _____
Been treated for nerve or spine disorder? ☐ Yes ☐ No Reason: _____
Been hospitalized for reason other than surgery? ☐ Yes ☐ No Reason: _____

PLEASE CHECK PAST SURGICAL HISTORY

Ankle ____ / ____ / ____	Appendix ____ / ____ / ____	Augmentation ____ / ____ / ____
Back/Spine ____ / ____ / ____	Breast Reduction ____ / ____ / ____	Cancer ____ / ____ / ____
Carpel Tunnel ____/ ____ / ____	Cataracts ____ / ____ / ____	Chest _____ / _____ / _____
Colon ____ / ____ / ____	C Section ____ / ____ / ____	Ears, Nose, Throat ____ / ____ / ____
Disc ____ / ____ / ____	Ears, Nose, Throat ____ / ____ / ____	Elbow ____ / ____ / ____
Eye ____ / ____ / ____	Foot ____ / ____ / ____	Gall Bladder____ / ____ / ____
Gastric Bypass ____ / ____ / ____	Hand ____ / ____ / ____	Heart ____ / ____ / ____
Hemorrhoids ____ / ____ / ____	Hernia ____ / ____ / ____	Hip Replacement _____ / _____/ _____
Hysterectomy ____ / ____ / ____	Kidney ____ / _____ / _____	Knee _____ / _____ / _____
Low Back ____ / ____ / ____	Mastectomy ____ / ____ / ____	Mid Back ____ / ____ / ____
Neck ____ / ____ / ____	Shoulder ____ / ____ / ____	Sinus ____ / ____ / ____
Throat ____ / ____ / ____	Thyroid ____ / ____ / ____	Tonsillectomy ____ / ____ / ____
Tubal Ligation ____ / ____ / ____	Tumor ____ / _____/ _____	Vasectomy ____ / ____ / ____
Wrist ____ / ____ / ____		

PLEASE LIST ANY SURGERIES NOT LISTED ABOVE

_____ ____ / ____ / ____ _____ ____ / ____ / _____

_____ ____ / ____ / ____ _____ ____ / ____ / _____

KINSTON CHIROPRACTIC PA Dr. Gary L. Wojeski NAME _____ ACCT # _____

NUMBER OF CHILDREN YOU HAVE: _____

FAMILY HISTORY (Please check any conditions that you or your family members have or had in the past) ☐ **NONE**

Arthritis ☐ Parent ☐ Sibling	**Heart Disease** ☐ Parent ☐ Sibling	**High Blood Pressure** ☐ **Parent** ☐ **Sibling**
Cancer ☐ Parent ☐ Sibling	**Thyroid** ☐ Parent ☐ Sibling	**High Cholesterol** ☐ **Parent** ☐ **Sibling**
Diabetes ☐ Parent ☐ Sibling	**Stroke** ☐ Parent ☐ Sibling	**Psychiatric Illness** ☐ **Parent** ☐ **Sibling**
Osteoporosis ☐ Parent ☐ Sibl**ing**		

Please list general health of family: (State if living or deceased and general health status)

Mother	☐ **Living**	**Health:** ☐ **Good** ☐ **Poor**	☐ **Deceased/Cause**	☐ **Natural** ☐ **Illness** _____
Father	☐ **Living**	**Health:** ☐ **Good** ☐ **Poor**	☐ **Deceased/Cause**	☐ **Natural** ☐ **Illness** _____
Sister 1	☐ **Living**	**Health:** ☐ **Good** ☐ **Poor**	☐ **Deceased/Cause**	☐ **Natural** ☐ **Illness** _____
Sister 2	☐ **Living**	**Health:** ☐ **Good** ☐ **Poor**	☐ **Deceased/Cause**	☐ **Natural** ☐ **Illness** _____
Brother 1	☐ **Living**	**Health:** ☐ **Good** ☐ **Poor**	☐ **Deceased/Cause**	☐ **Natural** ☐ **Illness** _____
Brother 2	☐ **Living**	**Health:** ☐ **Good** ☐ **Poor**	☐ **Deceased/Cause**	☐ **Natural** ☐ **Illness** _____
_____	☐ **Living**	**Health:** ☐ **Good** ☐ **Poor**	☐ **Deceased/Cause**	☐ **Natural** ☐ **Illness** _____
_____	☐ **Living**	**Health:** ☐ **Good** ☐ **Poor**	☐ **Deceased/Cause**	☐ **Natural** ☐ **Illness** _____

MEDICAL HISTORY *<u>Check All Illnesses You Have Now Or Have Had In The Past</u>* ☐ **None**

Addison's ☐ **HAVE** ☐ **HAD**	**Depression** ☐ **HAVE** ☐ **HAD**	**Low Blood Pressure** ☐ **HAVE** ☐ **HAD**
AIDS ☐ **HAVE** ☐ **H*AD***	**Diabetes** ☐ **HAVE** ☐ **HAD**	**Lupus** ☐ **HAVE** ☐ **HAD**
Alcoholism ☐ **HAVE** ☐ **HAD**	**Endometriosis** ☐ **HAVE** ☐ **HAD**	**Lyme's Disease** ☐ **HAVE** ☐ **HAD**
Alzheimer's ☐ **HAVE** ☐ **HAD**	**Epilepsy** ☐ **HAVE** ☐ **HAD**	**Malaria** ☐ **HAVE** ☐ **HAD**
Anemia ☐ **HAVE** ☐ **HAD**	**Eczema** ☐ **HAVE** ☐ **HAD**	**Measles** ☐ **HAVE** ☐ **HAD**
Aneurysm ☐ **HAVE** ☐ **HAD**	**Emphysema** ☐ **HAVE** ☐ **HAD**	**Mononucleosis** ☐ **HAVE** ☐ **HAD**
Type: _____ Size: _____	**Fibroid** ☐ **HAVE** ☐ **HAD**	**Multiple Sclerosis** ☐ **HAVE** ☐ **HAD**
Appendicitis ☐ **HAVE** ☐ **HAD**	**Fibromyalgia** ☐ **HAVE** ☐ **HAD**	**Mumps** ☐ **HAVE** ☐ **HAD**
Arteriosclerosis ☐ **HAVE** ☐ **HAD**	**Gall Bladder** ☐ **HAD** ☐ **HAD**	**Osteoporosis** ☐ **HAVE** ☐ **HAD**
Arthritis ☐ **HAVE** ☐ **HAD**	**Goiter** ☐ **HAVE** ☐ **HAD**	**Pacemaker** ☐ **HAVE** ☐ **HAD**
Asthma ☐ **HAVE** ☐ **HAD**	**Gout** ☐ **HAVE** ☐ **HAD**	**Polio** ☐ **HAVE** ☐ **HAD**
Bleeding Disorder ☐ **HAVE** ☐ **HAD**	**Heart Attack** ☐ **HAVE** ☐ **HAD**	**Rheumatic Fever** ☐ **HAVE** ☐ **HAD**
Cancer ☐ **HAVE** ☐ **HAD**	**Hemorrhoids** ☐ **HAVE** ☐ **HAD**	**Stroke** ☐ **HAVE** ☐ **HAD**
Type: _____	**Hepatitis** ☐ **HAVE** ☐ **HAD**	**Thyroid** ☐ **HAVE** ☐ **HAD**
Celiac Disease ☐ **HAVE** ☐ **HAD**	**High Blood Pressure** ☐ **HAVE** ☐ **HAD**	**Tonsillitis** ☐ **HAVE** ☐ **HAD**
Chicken Pox ☐ **HAVE** ☐ **HAD**	**High Cholesterol** ☐ **HAVE** ☐ **HAD**	**Tuberculosis** ☐ **HAVE** ☐ **HAD**
Crohn's Disease ☐ **HAVE** ☐ **HAD**	**Incontinence** ☐ **HAVE** ☐ **HAD**	**Ulcers** ☐ **HAVE** ☐ **HAD**
Colitis ☐ **HAVE** ☐ **HAD**	**Irregular Heart Beat** ☐ **HAVE** ☐ **HAD**	**Vertigo** ☐ **HAVE** ☐ **HAD**
Cystitis ☐ **HAVE** ☐ **HAD**	**Irritable Bowel** ☐ **HAVE** ☐ **HAD**	**Whooping Cough** ☐ **HAVE** ☐ **HAD**
Kidnery Stones ☐ **HAVE** ☐ **HAD**	**Kidney Disease** ☐ **HAVE** ☐ **HAD**	**Menstrual Problems** ☐ **HAVE** ☐ **HAD**

Are there any other health concerns that you feel the Doctor should know about: _____

_____

SOCIAL HISTORY ☐ **Decline To Answer**

Alcohol ☐ **Never** ☐ **Occasional** ☐ **Often** ☐ **Daily**
Caffeine ☐ **Never** ☐ **Occasional** ☐ **Often** ☐ **Daily**
Water ☐ **Never** ☐ **Occasional** ☐ **Often** ☐ **Daily**
Exercise ☐ **Never** ☐ **Occasional** ☐ **Often** ☐ **Daily**
Stress Level ☐ **None** ☐ **Mild** ☐ **Moderate** ☐ **Severe**
What contributes to your stress: ☐ **Job** ☐ **Family** ☐ **Finances** ☐ **Health**

HOW MUCH SLEEP DO YOU RECEIVE IN A DAY?
_____ hours **DO YOU SLEEP WELL** ☐ YES ☐ NO
IF NO, WHY? (PAIN. MATTRESS. INSOMNIA. CHILD, ETC.)
_____

KINSTON CHIROPRACTIC PA Dr. Gary L. Wojeski NAME _____ ACCT # _____

PLEASE GIVE US INFORMATION ON WHY YOU ARE SEEKING CARE AT OUR OFFICE:

(ONSET) When did your symptoms start? MONTH _____ DAY _____ YEAR _____

THE SYMPTOM(S) ARE THE RESULT OF: An accident or injury, if yes ☐ Work ☐ Auto
☐ Activity PLEASE DESCRIBE IN #2 BELOW

1. LOCATION OF YOUR MAIN COMPLAINT:

☐ HEAD ☐ NECK ☐ ARM
☐ MID BACK ☐ SHOULDER
☐ LOW BACK ☐ HIP ☐ KNEE
☐ LEG/S

2. Please Describe How Your Symptoms Started?

_____
_____
_____

Have You Had This Condition Before ☐ No ☐ Yes
If yes, when? _____

3. QUALITY OF SYMPTOMS:
(What Does It Feel Like?)
Check All That Apply
☐ Numbness ☐ Tingling ☐ Stiffness/Tightness
☐ Burning ☐ Aching/Dull ☐ Cramping ☐ Nagging
☐ Shooting ☐ Throbbing ☐ Sharp/Stabbing
☐ Other _____

4. INTENSITY (How severe are your current symptoms)

☐ 0 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 10 ☐
1 2 3 4 5 6 7 8 9
Absent Uncomfortable Unbearable

5. DOES THE PAIN RADIATE:
DOES THE PAIN RADIATE DOWN YOUR ARMS
☐ No if Yes ☐ Right or ☐ Left
DOES THE PAIN RADIATE DOWN YOUR LEGS
☐ No if ☐ Yes ☐ Right or ☐ Left

6. DURATION: (How often do you do you feel it)
☐ CONSTANT (76-100% of the day)
☐ FREQUENT (51-75% of the day)
☐ OCCASIONALLY (26-50% of the day)
☐ INTERMITTENTLY (0-25% of the day)

7. PRIOR TREATMENT (What have you done for symptoms?)
☐ Prescription Drugs ☐ Over the Counter Drugs
☐ Surgery ☐ Chiropractic ☐ Ice ☐ Heat
☐ Massage ☐ Acupuncture ☐ Other _____
Did these treatment/s help? ☐ Yes ☐ No

8. THE SYMPTOM(s) ARE GETTING: ☐ Better
☐ Progressively Worse ☐ Staying the same

9. HAVE YOU HAD ANY PRIOR TREATMENTS:
Have You Seen Anyone Else For This Condition:
☐ Yes ☐ No (If yes, who)
Who: _____Date_____
Have You Had Physical Therapy For This Condition:
☐ Yes ☐ No (If yes, who)
Who: _____Date_____

Have You Had Steroids Or Injections For This Condition:
Yes ☐ No (If yes, who) Date_____
Have You Had Any Other Tests For This Condition:
☐ X-rays ☐ MRI ☐ CT Scan ☐ Other _____
Where: _____ Date: _____

10. DO YOU HAVE HOBBIES THAT STRAIN YOUR SPINE?
☐ Golf ☐ Bowling ☐ Fishing ☐ Yard Work ☐ Other _____

11. Which ACTIVITIES MAKE YOUR PAIN WORSE?
☐ Sitting **☐ Standing ☐ Laying ☐ Getting Up and Down**
☐ Walking ☐ Other _____

12. IS THERE ANY CHANCE YOU ARE PREGNANT? ☐ Yes ☐ No
IF YES, HOW MANY WEEKS? _____ DUE DATE: _____

13. PLEASE LIST ANY DISABILITIES YOU HAVE _____
_____

14. Have You Been Seen Be a Chiropractor Before?
☐ No ☐ Yes If yes, clinic/doctor name? _____
Location _____
Date of Last Treatment _____
Same Condition ☐ Yes ☐ No
If No, list problem/condition? _____

15. OCCUPATION (Please Check Your Job Description (Check all the Apply)
☐ Sitting ☐ Standing ☐ Walking ☐ Lifting/Moderate
☐ Lifting/Heavy ☐ Bending ☐ Twisting ☐ Driving
☐ Light Manual Labor ☐ Heavy Manual Labor

KINSTON CHIROPRACTIC PA Dr. Gary L. Wojeski NAME _____ ACCT # _____

ACTIVITIES OF DAILY LIVING (How does this condition currently interfere with your life and ability to function.)

☐ **Bathing**	☐ **Getting In and Out of Car**	☐ **Sexual Activity**
☐ **Bending**	☐ **Getting up from chair**	☐ **Shopping**
☐ **Care of Others/Pets**	☐ **Housework**	☐ **Showering**
☐ **Caring for Children**	☐ **Knitting**	☐ **Sitting**
☐ **Carrying Objects**	☐ **Jogging**	☐ **Sleeping**
☐ **Cleaning House**	☐ **Lifting**	☐ **Standing**
☐ **Climbing stairs**	☐ **Light/Sound**	☐ **Turning Head**
☐ **Concentrating**	☐ **Lying Down**	☐ **Twisting**
☐ **Cooking**	☐ **Movement of Joints**	☐ **Using Computer**
☐ **Crouching/Squatting**	☐ **Mowing**	☐ **Walking**
☐ **Hobbies (list below)** _____	☐ **Normal Activities of Daily Living**	☐ **Working**
☐ **Dressing**	☐ **Personal Hygiene/ Grooming**	☐ **Yard Work**
☐ **Driving**	☐ **Pushing Pulling w/Hands**	☐ _____
☐ **Exercising/Sports**	☐ **Reaching Out/Up/Down**	☐ _____
☐ **Gardening**	☐ **Running**	☐ _____
☐ **General Mobility**	☐ **Sewing**	☐ _____

PLEASE LIST ANY OTHER HEALTH RELATED COMPLAINTS OR QUESTIONS THAT YOU WOULD LIKE TO TALK TO DR. WOJESKI ABOUT:

_____

_____

Our Non-Discrimination Statement
Kinston Chiropractic PA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This practice does not exclude people or treat them differently because of race, color, national origin, age disability, or sex.

I have read and reviewed all the information that I have supplied on this case history and attest that all the information that I have given is accurate to the best of my ability.

_____
Signature of Patient or Authorized Representative

_____ _____
Printed Name of Patient or Authorized Representative **Date**

I have reviewed the information submitted:

Dr. Gary L. Wojeski, DC

_____
Doctor Printed Name

_____ _____
Doctor Signature Date

KINSTON CHIROPRACTIC PA Dr. Gary L. Wojeski NAME _____ ACCT # _____

Have you have had a fever or chills during the past week? ☐ No ☐ Yes

PLEASE USE THE CHART TO INFORM US OF ANY OTHER MEDICAL CONDITIONS WE SHOULD KNOW ABOUT.

Cardiovascular: ☐ NO if, Yes

	Past	Present
Poor Circulation	☐	☐
High Blood Pressure	☐	☐
Aortic Aneurism	☐	☐
Heart Disease	☐	☐
Heart Attack	☐	☐
Chest Pain	☐	☐
High Cholesterol	☐	☐
Pace Maker	☐	☐
Jaw Pain	☐	☐
Irregular Heart Beat	☐	☐
Swelling of Legs	☐	☐

Genitourinary: ☐ NO if, Yes

	Past	Present
Kidney Disease	☐	☐
Lower Side Pain	☐	☐
Burning Urination	☐	☐
Frequent Urination	☐	☐
Blood Urine	☐	☐
Kidney Stone	☐	☐
Prostrate Problems	☐	☐

Hematologic/Lymphatic: ☐ NO if, Yes

	Past	Present
Hepatits	☐	☐
Blood Clots	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Fever/ Chills/Sweats	☐	☐
Cancer	☐	☐
**Location of Cancer	☐	☐

_____

Endocrine: ☐ NO if, Yes

	Past	Present
Thyroid Disease	☐	☐
Diabetes	☐	☐
Hair Loss	☐	☐
Menopausal	☐	☐
Menstrual Problems	☐	☐

Psychiatric: ☐ NO if, Yes

	Past	Present
Depression	☐	☐
Anxiety	☐	☐
Unusual Stress	☐	☐

Respiratory ☐ NO if, Yes

	Past	Present
Asthma	☐	☐
Tuberculosis	☐	☐
Shortness of Breath	☐	☐
Emphysema	☐	☐
Cold/Flu	☐	☐
Coughing/Wheezing	☐	☐

Ear/Nose/Throat: ☐ NO if, Yes

	Past	Present
Dizziness	☐	☐
Hearing Loss	☐	☐
Sinus Problems	☐	☐
Nosebleed	☐	☐
Sore Throat	☐	☐
Difficulty Swallowing	☐	☐
Bleeding Gums	☐	☐

Eyes: ☐ NO if, Yes

	Past	Present
Glaucoma	☐	☐
Double Vision	☐	☐
Blurred Vision	☐	☐

Neurological: ☐ NO if, Yes

	Past	Present
Seizures	☐	☐
Head Injury	☐	☐
Brain Aneurysm	☐	☐
Numbness	☐	☐
Severe Headaches	☐	☐
Pinched Nerves	☐	☐
Seizures	☐	☐
Parkinson's	☐	☐
Carpal Tunnel	☐	☐
Spinning Balance	☐	☐
Epilepsy	☐	☐
Fainting	☐	☐

Constitutional: ☐ NO if, Yes

	Past	Present
Energy Level Problem	☐	☐
Difficulty Sleeping	☐	☐
Weight Loss/Gain	☐	☐

Allergic/Immunologic ☐ NO if, Yes

	Past	Present
Hives	☐	☐
Immune Disorder	☐	☐
HIV/AIDS	☐	☐
Allergy Shots	☐	☐
Cortisone Use	☐	☐

Gastrointestinal: ☐ NO if, Yes

	Past	Present
Gallbladder Problems	☐	☐
Bowel Problems	☐	☐
Constipation	☐	☐
Liver Problems	☐	☐
Ulcers	☐	☐
Diarrhea	☐	☐
Nausea/Vomiting	☐	☐
Bloody Stools	☐	☐
Poor Appetite	☐	☐
Loss of Bladder Control	☐	☐
Heartburn/Indigestion	☐	☐

Integumentary: ☐ NO if, Yes

	Past	Present
Skin Ulcers	☐	☐
Skin Disease	☐	☐
Eczema	☐	☐
Psoriasis	☐	☐
Rashes	☐	☐

Musculoskeletal: ☐ NO if, Yes

	Past	Present
Arthritis	☐	☐
Joint Stiffness	☐	☐
Muscle Weakness	☐	☐
Osteoporosis	☐	☐
Gout		

Permanent Disabilty Rating _____ %

Other Conditions _____

_____

DOCTOR'S SIGNATURE _____ DATE _____

Dr. Gary L. Wojeski DC

KINSTON CHIROPRACTIC PA Dr. Gary L. Wojeski NAME _____ ACCT # _____

ASSIGNMENT OF BENEFITS AND RELEASE

"I, the undersigned certify that I (or my dependent) assign, transfer and set over directly to Kinston Chiropractic PA all proceeds of any insurance policy or other health care plan, otherwise payable to me. I hereby direct payment be made directly to the above named facility and allow Kinston Chiropractic PA to stand in my place and receive all payments for settlement purposes for the value of services rendered.

I hereby authorize, the doctor to release to necessary parties, including my attorney, third party agency, or any insurance company, all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

It is understood and agreed that the amount paid Kinston Chiropractic PA for x-rays is for examination only and the x-rays and/or negatives will remain the property of this office. All reports and findings will be made available to the patient. X-rays may be checked out upon request but all negatives must be returned to Kinston Chiropractic PA in a timely manner.

_____ _____

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY **DATE**

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **RELATIONSHIP TO PATIENT**

PATIENT NOTIFICATION OF FINANCIAL RESPONSIBILTY

I understand that I remain financially responsible for any and all charges incurred at this office and not covered by the insurance proceeds or contractual agreements, including co-payments, deductibles, and denied charges.

I realize that my care may be subject to pre-authorization by my insurance company and to the extent that Kinston Chiropractic PA will do everything in their power to procure authorization and/or payment, I accept responsibility for any treatments, which are determined medically unnecessary.

I understand that my insurance coverage may not cover visits considered routine maintenance, preventative, or wellness visits.

I have read and/or been explained my rights and understand my obligations for payment of care in the absence of insurance coverage.

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ THE FOREGOING, AND IS THE PATIENT OR OTHER RESPONSIBLE PARTY AND UNDERSTANDS AND ACCEPTS THE ABOVE CONDITIONS AND TERMS

_____ _____

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY **DATE**

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **RELATIONSHIP TO PATIENT**

KINSTON CHIROPRACTIC PA Dr. Gary L. Wojeski NAME _____ ACCT # _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including but not limited to , muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through conservative approach hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payments(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants, and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunities to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PRINTED NAME OF PATIENT _____

SIGNATURE OF PATIENT _____

NAME PRINTED OF GUARDIAN/AUTHORIZED REPRESENTATIVE

_____ **RELATIONSHIP TO PATIENT/AUTHORITY** _____

GUARDIAN/AUTHORIZED REPRESENTATIVE SIGNATURE _____

DATE: _____

PRINTED NAME OF DOCTOR OF CHIROPRACTIC: DR. GARY L. WOJESKI DC

SIGNATURE OF DOCTOR OF CHIROPRACTIC _____

KINSTON CHIROPRACTIC PA Dr. Gary L. Wojeski NAME _____ ACCT # _____

PATIENT PREFERENCE FOR CONTACT AND RELEASE OF PHI

In general, the HIPAA rule gives individuals the right to request restrictions and authorizations for use of their protected health information (PHI). The individual also has the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending to the individuals office instead of home address. Individuals also have the right to grant authorization for other individuals to access their (PHI) protected health information.

I PREFER AND/OR GIVE MY PERMISSION TO BE CONTACTED IN THE FOLLOWING MANNER:

- ☐ **Home Phone Number _____**
- ☐ **Okay to leave a message with detailed information.**
- ☐ **Please do not contact me at Home**

- ☐ **Work Number _____**
- ☐ **Okay to leave a detailed message**
- ☐ **Please do not contact me at Work**

- ☐ **Written Communication**
- ☐ **Okay to mail to home address**
- ☐ **Okay to mail to work/office address**
- ☐ **Okay to fax _____**
- ☐ **Other _____**
- ☐ **Please do not send written communication to my Work**
- ☐ **Please do not Fax any written communication**

I give my authorization for the following individual(s) to receive information concerning any protected health information.

_____ Relationship_____ DOB _____

Specific information this individual may receive: Appointment Information Only Any and all information pertaining to my treatment and prognosis.

_____ Relationship_____ DOB _____

Specific information this individual may receive: ☐ Appointment Information Only ☐ Any and all information pertaining to my treatment and prognosis.

INDIVIDUALS ALSO HAVE THE RIGHT TO RESTRICT THE USE AND DISCLOSURE OF THEIR PHI:
If you would like to place any restrictions on the release of your PHI, please inform staff and we will supply you with a form.

I understand that I may revoke this authorization at any time by contacting Kinston Chiropractic PA and/or any person representing Kinston Chiropractic PA. I understand that Kinston Chiropractic PA or any person representing Kinston Chiropractic PA cannot give out any information protected under the HIPAA Privacy Act (unless otherwise stated in our Privacy Policy) to any individual other than myself without my written authorization above. If any information changes need to be made concerning this form I need to present it in writing or fill out a new form therefore, Kinston Chiropractic and its representatives will not honor any requests made over the phone.

This form will be effective until at which time it is revoked or amended in writing.

_____ _____

PRINTED NAME OF PATIENT/RESPONSIBLE PARTY SIGNATURE OF PATIENT/RESPONSIBLE PARTY

_____

DATE

KINSTON CHIROPRACTIC PA Dr. Gary L. Wojeski NAME _____ ACCT # _____

Consent for Purpose of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Kinston Chiropractic Pa, Dr. Gary L. Wojeski and/or its representatives for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Kinston Chiropractic PA.

I understand I have the right to request a restriction as to how my protected health information is used and/or disclosed to carry out treatment, payment or health care operations of the practice. Kinston Chiropractic PA and its representatives are not required to agree to the restrictions that I may request. However, if Kinston Chiropractic, PA or its representatives agrees to a restriction that I request, the restriction is binding on Kinston Chiropractic PA and its representatives.

I have the right to revoke this consent, in writing, at any time, except to the extent that Kinston Chiropractic PA and its representatives have taken action in reliance on the consent.

My PHI or "protected health information" is my health information, including any demographic information, collected from me and created for received by Kinston Chiropractic and its representatives, another health care provider, a health plan, my employer or a health plan clearinghouse. This protected health information relates to my past, present, and/or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

THE NOTICE OF PRIVACY PRACTICES describes the types pf uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, and/or in the performance of health care operations of Kinston Chiropractic PA.

THE NOTICE OF PRIVACY PRACTICES also describes my rights and the duties of Kinston Chiropractic PA and its representatives with respect to my protected health information.

THE FULL NOTICE OF PRIVACY PRACTICES for Kinston Chiropractic PA is posted on the bulletin board in the reception area, in each of the treatment rooms of Kinston Chiropractic PA, as well as on Kinston Chiropractic, PA's web site at www.kinstonchiro.homestead.com. Printed copies are also available in the reception area for your convenience.

Kinston Chiropractic, PA reserves the right to change the privacy practices that are described in the **NOTICE OF PRIVACY PRACTICES**. If any changes are made Kinston Chiropractic PA will **post the new notice in the areas designated in the paragraph above, and a new copy will be offered to me upon my next visit.**

I understand that a **NOTICE OF PRIVACY PRACTICES will be provided to me. If I choose not to accept it and change my mind, I may obtain a copy at any time by** accessing Kinston Chiropractic PA's website, calling Kinston Chiropractic PA's office and requesting a copy to be given to me at the time of my next appointment, or request one be sent to me in the mail.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the NOTICE OF PRIVACY PRACTICES, and that I have read them, or declined the opportunity to read them, and understand the NOTICE OF PRIVACY PRACTICES. I understand this form will be placed in my patient chart and maintained for 6 years. .

PRINTED NAME OF PATIENT/AUTHORIZED REPRESENTATIVE: _____

SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE: _____

DESCRIPTION OF PERSONAL REPRESENTATIVES AUTHORITY: _____

DATE: _____ **DATE OF EXPIRATION:** _____

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR 6 YEARS

Our Non-Discrimination Statement
Kinston Chiropractic PA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This practice does not exclude people or treat them differently because of race, color, national origin, age disability, or sex.