Kara Rosenstrauch, D.C.
1864 Woodmoor Dr. #201
Monument, CO 80132

Patient History Today's Date

Last _____ First _____ Middle Initial _____

Date of Birth _____ Age _____ Social Security # _____

Address _____ City _____ ST _____ Zip _____

Phone (Home)_____(Work)_____(Cell)_____

Email: May we send you our online newsletter? Yes No Email Address: _____

Your Occupation_____ Employer_____

Spouse's Name _____ Spouse DOB _____ Spouse SSN:_____

Have you been to another doctor for this problem? Yes No Who/Where? _____

Who may we thank for referring you to this office? _____

What brings you to our office? Please provide as much detail as possible.

PRIMARY COMPLAINT: _____

Date when symptom first appeared_____ Did It begin: Gradual | Sudden | Progressive Over-time

What makes the symptoms increase? _____ What relieves the symptoms? _____

Type of Pain: Sharp Dull | Ache | Burn | Throb Does the pain radiate into your: Arm L R Both | Leg L R Both | Does not radiate

Do you have numbness or tingling? Yes No How often do you experience these symptoms? 100% 75% 50% 25% 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____

Please list all previous treatments for this condition (give doctor's name end dates If possible) _____
_____

Do you have any family members who suffer from this complaint? If so, who? _____

SECONDARY COMPLAINT: _____

Date when symptom first appeared_____ Did It begin: Gradual | Sudden | Progressive Over-time

What makes the symptoms increase? _____ What relieves the symptoms? _____

Type of Pain: Sharp Dull | Ache | Burn | Throb Does the pain radiate into your: Arm L R Both | Leg L R Both | Does not radiate

Do you have numbness or tingling? Yes No How often do you experience these symptoms? 100% 75% 50% 25% 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____

Please list all previous treatments for this condition (give doctor's name end dates, If possible) _____

Do you smoke? Yes No If yes, how many packs per week? _____

Have you ever smoked in the past? Yes No If yes, when did you quit? _____

Do you take birth control? Yes No Have you ever taken birth control in the past? Yes No

Do you consume alcohol? Yes No If yes, how many drinks per week? _____

Do you consume caffeine? Yes No If yes, how many drinks per day? _____

Do you exercise? Yes No If yes, how many times per week and what type? _____

Do you have a high stress level? Yes No If yes, list reasons_____

Please list any medications or vitamins you are taking:

_____

_____

_____

_____

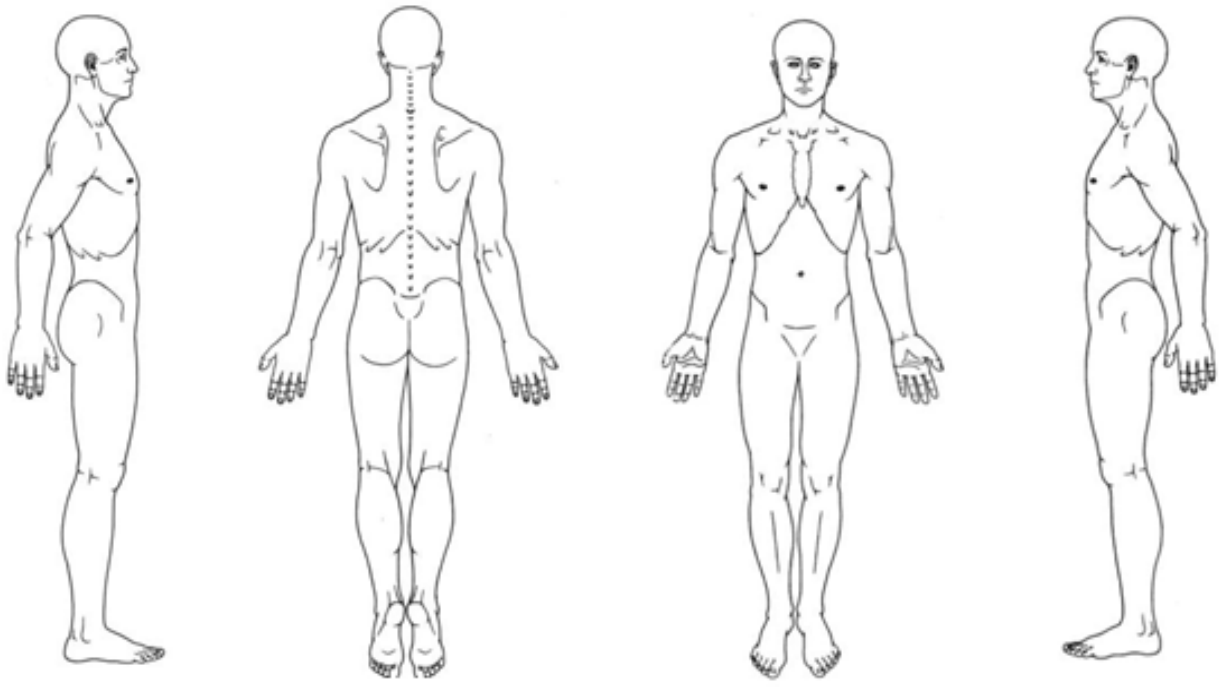
_____

PATIENTSIGNATURE_____ DATE _____

PATIENT HISTORY

Please mark off the areas of complainton the diagram below.

PPP=Pain **NNN**=Numbness **TTT**=Tingling **BBB**=Burning **CCC**=Cramping **XXX**=Other



Please list all surgeries, injuries, accidents, falls etc:

_____

_____

_____

_____

_____

☐ AIDS/HIV	☐ Alcoholism	☐ Anemia	☐ Allergy Shots
☐ Anorexia	☐ Arthritis	☐ Asthma	☐ Bleeding Disorders
☐ Bronchitis	☐ Bulimia	☐ Cancer	☐ Cataracts
☐ Chicken Pox	☐ Diabetes	☐ Disc Degeneration	☐ Emphysema
☐ Epilepsy	☐ Glaucoma	☐ Goiter	☐ Gonorrhea
☐ Heart Attack	☐ Heart Disease	☐ Hepatitis	☐ Hernia
☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Liver Disease
☐ Migraine	☐ Miscarriage	☐ Mononucleosis	☐ Multiple Sclerosis
☐ Osteoporosis	☐ Pacemaker	☐ Parkinson's Disease	☐ Pinched Nerve
☐ Polio	☐ Prostate Problem	☐ Prosthesis	☐ Psychiatric Care
☐ Rheumatic Fever	☐ Scarlet Fever	☐ Suicide Attempt	☐ Thyroid Problems
☐ Tuberculosis	☐ Tumors/Growths	☐ Typhoid Fever	☐ Ulcers
☐ Vaginal Discharge	☐ Venereal Disease	☐ Whooping Cough	☐ Rheumatoid Arthritis
☐ Other			

_____ _____ _____

Patient Signature or (Legal Guardian) Printed Name Date

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Consent Form for Chiropractic

Chiropractic focuses on the nervous system and the spinal cord. During chiropractic treatment, the doctor will use his/her hands or a mechanical device in order to align your spine to correct interference to the nervous system and improve the body's ability to control and coordinate many functions. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joint, or injury to intervertebral discs, nerves or spinal cord. Stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment.

The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of stroke has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures.

I,_____, understand the hazards and potential dangers involved in treatment by means of chiropractic. I believe that this treatment is in my best interest and I understand that no guarantee of results has been made.
I understand that it usually requires a series of chiropractic treatments to significantly change a condition and receive benefit.

Laser Therapy: The MR4 Super Pulsed Laser has been designated "unproven" by the Colorado State Board of Chiropractic Examiners. By signing below, you are stating that permission is granted by to **proceed with Laser Therapy.**

My signature indicates that I have read and fully understand the above information regarding the consent to this procedure. My signature below authorizes this procedure should I require it for my condition.

_____ _____ _____
Patient Signature or (Legal Guardian) Printed Name Date

Practitioner Statement: The patient (or patient's representative) and I have discussed this procedure, the risks and alternatives to this procedure. To the best of my knowledge, the patient (or patient's representative) understands this procedure and consents to it.

_____

Practitioner Signature / Practitioner Printed Name / Date

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Receipt of Notice of Privacy Practices Written Acknowledgement Form

The Practice:
1) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

2) May be required by Colorado law to maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

3) ls required to abide be the terms of the Privacy Notice.

4) Reserves the right to change the terms of the Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

5) Will distribute any revised Privacy Notice to you prior to implementation.

6) Will not retaliate against you for filing a complaint.

This Notice is in effect as of 03/14/03.

I,_____, have received a copy of Kara Rosenstrauch's Notice of Privacy Practices.

_____ _____ _____
Patient Signature or (Legal Guardian) Printed Name Date

Patient's acknowledgement of this Notice could not be obtained

because:

1. Patient refused to sign
2. Communication barrier prohibited obtaining acknowledgement
3. Emergency Circumstances
4. Other:

_____

Practitioner Signature / Practitioner Printed Name / Date