

# 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 \_\_\_\_\_

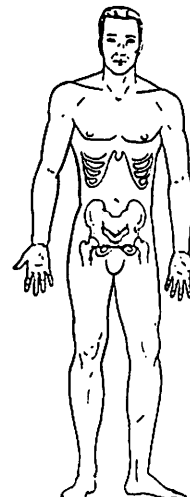
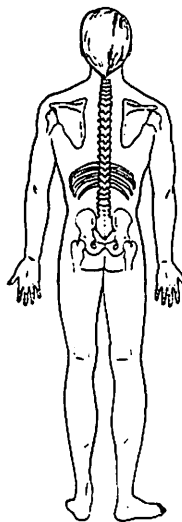
Please mark area & type of pain on the drawings using the codes listed below

Please mark the intensity of your pain today

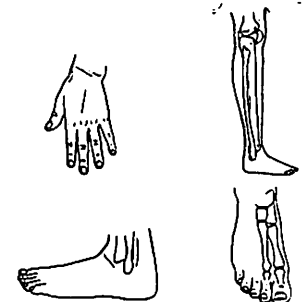
1= NO PAIN

10= MOST INTENSE EVER FELT

Example 1-2-3-4-5-6-7-8-9-10-  
 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

Smoking Packs/Day: \_\_\_\_\_  
 Alcohol Drinks/Day: \_\_\_\_\_  
 Coffee/Soda Cups/Day: \_\_\_\_\_  
 Water Cups/Day: \_\_\_\_\_

None  
 Moderate  
 Daily  
 Type: \_\_\_\_\_

	Diabetes	Heart	Cancer	Back
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings, # of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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?**

- |  |                                      |   |  |
|--|--------------------------------------|---|--|
| <input type="checkbox"/> Appendicitis    | <input type="checkbox"/> Anemia      | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Arthritis       |
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Measles     | <input type="checkbox"/> Goiter           | <input type="checkbox"/> Epilepsy        |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps       | <input type="checkbox"/> Influenza        | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pleurisy         | <input type="checkbox"/> Lumbago         |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Eczema          |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Cancer      | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> 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 <u>GENERAL SYMPTOMS</u>	N O F <u>GASTRO-INTESTINAL</u>	N O F <u>EYE/EAR/NOSE/THROAT</u>	N O F <u>RESPIRATORY</u>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy (what) _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Belching or Gas	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest Pain
_____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colon Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deafness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic Cough
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Earache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear Discharge	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting Blood
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear Noises	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting Phlegm
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gall Bladder Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged Thyroid	<u>GENITO-URINARY</u>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids (piles)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent Colds	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed Wetting
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaundice	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay Fever	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in Urine
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hoarseness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent Urination
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of Weight	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nasal Obstruction	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Inability to Control Urine
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervousness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over Stomach	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney Infection
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Night Sweats	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Appetite	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Vision	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful Urination
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness or pain in arms/legs/hands	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Digestion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinusitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate Trouble
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wheezing	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore Throats	<u>FOR WOMEN ONLY</u>
<u>MUSCLES &amp; JOINTS</u>	<u>CARDIO-VASCULAR</u>	<u>SKIN OR ALLERGIES</u>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramps or Backache
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Backache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Boils	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive Flow
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruising Easily	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot Flashes
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain between Shoulders	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over Heart	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dryness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irregular Cycle
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful Tail Bone	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Circulation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eczema	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Miscarraige
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stiff Neck	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid Heart	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hives or Allergies	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful Periods
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spinal Curvature	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow Heart	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen Joints	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling Ankles	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sensitive Skin	<input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant at this time?
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose Veins	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 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: \_\_\_\_\_