MAESTRO CHIROPRACTIC & REHAB

2949 Swede Road, East Norriton, PA 19401
(T) 610-270-8888 (F) 610-270-8877

PATIENT REGISTRATION

Section 1: Patient Information

영어이름 English Name	한글이름 Korean Name	생년월일 DOB	성별 Sex 남 M/여 F	혼인여부 Marital Status 미혼 Single/기혼 Married

Social Security Number	집 전화 Home Tel	핸드폰 Mobile	이메일 E-mail

Street	City	State	Zip

취업여부 Employment Status	□취직 Employed	□학생 Student-part time	□학생 Student-full time	□은퇴 Retired	□무직 Unemployed	□주부 Homemaker

직장 Employer	학교 School

Section 2: Insurance Information

건강보험 Primary Health Insurance

보험회사 Insurance Company	보험회사 전화 Insurance Tel

보험번호 Member ID	가입자 성명 Insured's Name	가입자 생년월일 Insured's DOB	가입자와 관계 Relation to Insured

가입자 직장 Insured's Employer	가입자 직장 주소 Employer's Address

건강보험 Secondary Health Insurance

보험회사 Insurance Company	보험회사 전화 Insurance Tel

보험번호 Member ID	가입자 성명 Insured's Name	가입자 생년월일 Insured's DOB	가입자와 관계 Relation to Insured

가입자 직장 Insured's Employer	가입자 직장 주소 Employer's Address

자동차보험 (교통사고 환자) Automobile Insurance (automobile accident)

보험회사 Insurance Company	보험회사 전화 Insurance Tel

보험번호 Policy No.	가입자 성명 Policy Holder's Name	사고날짜 Accident Date	Claim No.

Claim 담당자 성명 Adjuster's Name	Claim 담당자 전화 Adjuster's Tel

사고 담당 변호사 성명 Attorney Name	변호사 사무실 이름 Firm	변호사 전화 Attorney Tel

Referral Information

저희 병원을 어떻게 알게 되셨습니까? How did you hear about us?

□다른 환자 another patient □다른 병원 physician office □신문 newspaper □전화번호부 yellow page □LA Fitness □Walk-in □Other

저희 병원을 소개해주신 분 성명을 써 주십시요. Name of Person Referring You to Our Office

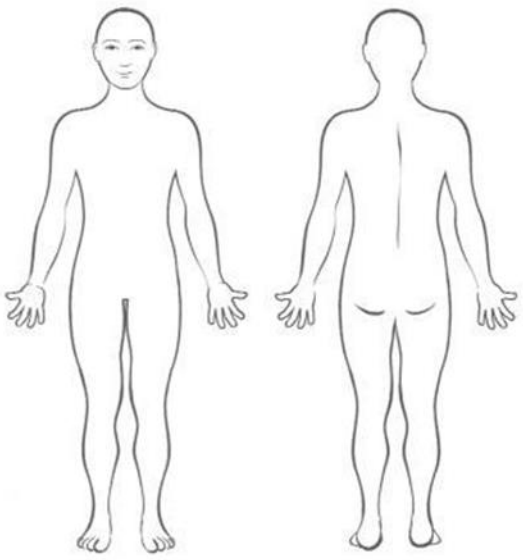
Section 3: Current Complaints

오늘 병원을 찾아오신 이유(통증이 있으시 곳을 써주십시요.) Where do you have pain?

사고로 인한 통증이십니까? Is pain due to an accident? Yes/No	통증 시작 날짜 Pain Started On	일을 하실수 없으셨습니까? Unable to Work? Yes/No	일 할수 없었던 날짜 Unable to Work From-To Date

통증이 시작된 이유 How did this pain start?

통증이 있는 부위를 표시해 주십시요.
Mark Where You Have Pain



통증의 종류 Type of Pain	□에이는 sharp	□둔한 dull	□시큰시큰한 throbbing	□무감각한 numbness
	□쑤시는 aching	□쏘는듯한 shooting	□욱신거리는 burning	□톡톡쏘는 tingling
	□경련 cramps	□뻣뻣한 stiffness	□부음 swelling	□다른곳으로 이전되는 radiating
	□그 외 other:			

통증의 빈도 Pain Frequency	□끊임없는 *(76-100%/day)*	□잦음 *(51-75%/day)*	□가끔 *(25-50%/day)*	□간간히 *(0-25%/day)*

통증을 악화시키는 자세 Pain Worsened	□앉아있을때 sitting	□서있을때 standing	□걸을때 walking	□뛸때 running
	□구부릴때 bending	□누워있을때 lying down	□물건을 들때 lifting	□운전할때 driving
	□그 외 other:			

언제 통증이 완화 되십니까? Pain Relieved by

지장받는 활동 Pain Interferes	□일 work	□수면 sleep	□여가활동 recreation	□일상생활 daily routine

통증 강도 Pain Scale

0=없음 no pain
1-3=약간 mild
4-6=보통 moderate
7-8=심한 severe
9-10=극심한 extreme

목 Neck 0 1 2 3 4 5 6 7 8 9 10	어깨/팔 Shoulder/Arm 0 1 2 3 4 5 6 7 8 9 10
등 Mid Back 0 1 2 3 4 5 6 7 8 9 10	허리 Low Back 0 1 2 3 4 5 6 7 8 9 10
골반/다리 Hip/Leg 0 1 2 3 4 5 6 7 8 9 10	발/발목 Foot/Ankle 0 1 2 3 4 5 6 7 8 9 10
두통 Headache 0 1 2 3 4 5 6 7 8 9 10	그 외 Other: 0 1 2 3 4 5 6 7 8 9 10

Section 4: Accident/Injury History

사고날짜 Accident Date	사고종류 Accident Type	□자동차 car	□버스 bus	□오토바이 motorcycle	업무와 관련된 사고이십니까? Work Related Accident? Yes/No
		□자전거 bicycle	□보행자 pedestrian	□미끄러짐 slip&fall	

앉아있던 좌석 You Were Seated	□운전자 Driver	□조수석 Front Passenger	□뒷자리 Back Passenger	벨트착용 Seat Belt Yes/No	에어백 Air Bags Deployed? Yes/No

자동차 손상정도 Vehicle Damage 최소 mild/보통 moderate/심각 severe/폐차 total loss	사고장소 Accident Site

사고상황을 자세히 기록해주십시요. How Accident Occurred

사고당시, 몸이: Upon Impact:	□경직됨 tensed	□앞,뒤로 흔들림 whipped front-back	□양옆으로 흔들림 whipped side-side	□뒤틀림 twisted	□부딛침 (어디에?): hit against
사고직후 증상: After Impact:	□정신을 잃음 unconsciousness	□메스꺼움 nausea	□어지러움 dizziness	□피로감 weakness	□그 외 other:
	□통증 부위 pain in:				

사고후, 병원에 가셨습니까? Were you taken to hospital? Yes/No	병원에 간 날짜 Visit Date	병원이름 Hospital Name

병원에 받으신 검사 Studies Done at Hospital □X-RAY □MRI □CT SCAN □그 외 Other:

사고후, 상담받으신 의사 성명 Other Physicians You Saw (Name)	의사 전화 Physician Tel	상담 받으신 날짜 Visit Date

Section 5: Medical History

담당 의사 성명 Primary Physician Name	의사 전화 Physician Tel

현재 & 과거의 증상을 모두 표시해주십시요. Check all that applies to your medical history.

□AIDS/HIV 감염	□당뇨 diabetes	□전염성 단핵증 infectious mono	□성홍열 scarlet fever
□빈혈증 anemia	□디프테리아 diphtheria	□신장병 kidney disease	□대상포진 shingles
□관절염 arthritis	□간질 epilepsy	□간질환 Liver disease	□천연두 smallpox
□등/허리 통증 back pain	□녹내장 glaucoma	□홍역 measles	□뇌졸중 stroke
□방광염 bladder infection	□심장병 heart disease	□두통 migraine	□갑상선 질환 thyroid disease
□출혈성 질환 bleeding tendency	□치질 hemorrhoids	□승모판 탈출증 (심장질환) mitral valve prolapse	□결핵 tuberculosis
□수혈 blood/plasma transfusions	□간염 hepatitis	□볼거리/유행성 이하선염 mumps	□궤양 ulcer
□기관지염 bronchitis	□탈장 hernia	□류머티스 열 rheumatic fever	□성병 venereal disease
□암 cancer	□고/저혈압 high/low blood pressure	□폐렴 pneumonia	□백일해 whooping cough
□수두 chickenpox	□습진/두드러기/아토피 eczema	□소아마비 polio	□그 외 other:

위에 명시되지 않은 현재 & 과거 병력을 모두 써 주십시요. Describe any current/past medical condition not listed above.

과거에 받은 수술을 모두 써 주십시요. Past Surgeries

현재 복용하는 약을 모두 써 주십시요. Current Medication

과거의 사고 또는 부상을 모두 써 주십시요. Past Accidents/Injuries

Section 6: Social History

흡연을 하십니까? Smoke/Tobacco Products Yes/No	"예"라면, 하루에 피는 정도 If yes, how much per day?	"아니요"라면, 과거에 흡연을 하셨습니까? If no, have you in the past? Yes/No
음주를 하십니까? Alcohols Yes/No	"예'라면, 한주에 몇번 정도 If yes, how much per week?	"아니요"라면, 과거에 음주를 하셨습니까? If no, have you in the past? Yes/No
커피 또는 차를 마십니까? Coffee/Tea Yes/No	"예"라면, 하루에 몇잔 정도 If yes, how much per day?	"아니요"라면, 과거에 마셨습니까? If no, have you in the past? Yes/No
운동을 하십니까? Exercise Yes/No	"예"라면, 한주에 몇일 정도 If yes, how many days per week?	

Section 7: Patient Signature

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

환자 서명 Patient Signature	날짜 Date

DOCTOR'S SIGNATURE:_____ D.C.

Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint(s). Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, x-ray, digital imaging, therapeutic ultrasound, dry hydrotherapy, axial traction, extension compression traction, rehabilitation, exercising and stretching, inter-segmental traction, flexion-distraction traction, therapy ball, massage therapy, soft tissue therapy, various topical pain relief creams and/or lotions, may also be used in conjunction with your treatment.

Possible risks: I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment. As with any health care procedure, complications are possible following a chiropractic manipulation. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. Complications, while extremely rare, could include but are not limited to: fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, and injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck.

Probability of risks occurring: 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 cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases. Medications such as Vioxx have been shown to cause heart damage & death.
- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence / addiction in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases. Many patient treated n hospital leave with conditions worse than their original complaint.
- *Surgery* in conjunction with medical care adds the risks of infection and adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases. Surgery can result in permanent loss of function or death.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult. Patients who do not follow their approved chiropractic treatment plan may revert to their original symptoms, or even become worse from failing to finish treatment.

For WOMEN: X-RAY RIKS

Are you pregnant or any chance you may be: _____ YES _____ NO

X-ray uses radiation which can have a severe health effect during pregnancy to an unborn baby. The possibility of severe health effects depends on the gestational age of the unborn baby at the time of exposure and the amount of radiation it is exposed to. Unborn babies are particularly sensitive to radiation during their early development, between weeks 2 and 15 of pregnancy. If you feel that you may be pregnant, please inform the chiropractor before your exam.

_____ To the best of my knowledge I am not pregnant or believe there is any possibility that I may be pregnant.
_____ I know or believe that I may be pregnant and fully understand the risk and health effects radiation may cause to my unborn baby.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction.

_____ _____

Signature of Patient or Personal Representative Date

Consent for Use and Disclosure of Health Information

SECTION A: PATIENT GIVING CONSENT

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

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

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

YOU MAY OBTAIN A COPY OF OUR NOTICE OF PRIVACY PRACTICES, INCLUDING ANY REVISIONS TO OUR NOTICE, AT ANY TIME BY CONTACTING:

Maestro Chiropractic & Rehab
2949 Swede Rd., East Norriton, PA 19401
(T)610-270-8888/(F)610-270-8877
maestrochiropractic@gmail.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ **Date:**_____

IF THIS CONSENT IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHALF OF THE PATIENT, PLEASE COMPLETE THE FOLLOWING:

Personal Representative's Name:_____

Relationship to Patient:_____