Review of Systems: ***Patient Name:*** ______________________

Have you had trouble with any of the following:

Cardiovascular: No ____

	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

Genitourinary: No ____

	Present	Past	No
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in urine			
Kidney Stone			

Hematologic/lymphatic: No ____

	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

Neurologic: No ____

	Present	Past	No
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			

Respiratory: No ____

	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

Ears/Nose/Throat: No ____

	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			

Eyes: No ____

	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

Integumentary: No ____

	Present	Past	No
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

Psychiatric: No ____

	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

Constitutional: No ____

	Present	Past	No
Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

Allergic/Immunologic: No ____

	Present	Past	No
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

Gastrointestinal: No ____

	Present	Past	No
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

Musculoskeletal: No ____

	Present	Past	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

Endocrine: No ____

	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			

All patients should complete this page

Patient Data **Date:** ____________

Title: ☐Mr. ☐Mrs. ☐Ms ☐Miss (check one)

First Name: ____________ **Middle Initial:** ____ **Last Name:** ____________

Address Line 1: ____________________________

Address Line 2: ____________________________

City: ____________ **State:** ____________ **Zip Code:** ____________

Home Phone: (____)______-________ **Work Phone:** (____)______-________

Cell Phone: (____)______-________

Date of Birth: ____/____/______ **Sex:** ☐Male ☐Female **Email:** ____________

Social Security Number: ______-____-________ **Marital Status:** ☐Single ☐Married ☐Other

Employment Status: ☐Employed ☐Full Time Student ☐Part Time Student ☐Other (check one)

Spouse Data

Is your spouse a patient in the clinic? ☐Yes ☐ No

First Name: ____________ **Middle Initial:** ____ **Last Name:** ____________

Home Phone: (____)______-________ **Work Phone:** (____)______-________

Employer Data

Name: ____________________________

Address Line 1: ____________________

Address Line 2: ____________________

City: ____________ **State:** ____________ **Zip Code:** ____________

Emergency Contact

Contact Name: ____________________________

Contact Phone: (____) ______-________

Created 7/31/07

All patients should complete this page

KOSTERMAN
CHIROPRACTIC CENTER

"Good Health for Life"

Frank E. Kosterman, D.C.
Timothy M. Kosterman, D.C.

401 Cooper Drive
Clinton, North Carolina 28328
(910) 592-2250 • Fax (910) 592-6149

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

DATE:

To: INSURANCE CARRIER _____ ATTORNEY _____ PHYSICIAN: _____ OTHER _____

Name: ____

Address: ____

____

Phone: ____

From: DR FRANK KOSTERMAN
DR. TIM KOSTERMAN
401 Cooper Drive
Clinton, NC 28328

I, the undersigned patient, authorize the above named doctor to release and/or obtain any information he deems appropriate concerning my health condition to/from any insurance company, attorney, or adjuster in order to process any claim for reimbursement of any/all services rendered.

I, also authorize said doctor to release and/or obtain any information he deems appropriate concerning my health condition to/from any physician or medical associate that he deems necessary for the most optimum outcome of my care.

I authorize and assign any responsible insurance companies, attorney, or other guarantor to make any/all payments directly to said doctor at his office address shown above.

This Authorization and Assignment will remain in effect until revoked by me in writing.
A photocopy of this document is to be considered as valid as an original.

PATIENT'S NAME: ______________________________ DATE: __________

SIGNATURE: ____

WITNESS: ____

All patients should complete this page

KOSTERMAN
CHIROPRACTIC CENTER

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Timothy M. Kosterman, D.C.

401 Cooper Drive
Clinton, North Carolina 28328
(910) 592-2250 • Fax (910) 592-6149

AUTHORIZATION TO OBTAIN INFORMATION

DATE: ____________________

TO: ____
____
____
____

From: Dr. Frank Kosterman
Dr. Tim Kosterman
401 Cooper Drive
Clinton, NC 28328

I, the undersigned patient, authorization Kosterman Chiropractic Center to obtain acute care records they deem necessary concerning my health condition from your facility for the most optimum outcome of my care.

This Authorization will remain in effect until revoked by me in writing.
A photocopy of this document is to be considered as valid as an original.

PATIENT'S NAME: ____

SIGNATURE: ________________________________ Date: ____________

WITNESS: ____

028 9/04/02st

All patients should complete this page

ACKNOWLEDGE OF RECEIPT

KOSTERMAN CHIROPRACTIC CENTER

As required by the Privacy Regulation, I hereby acknowledge that I have received a current copy of the Notice of Privacy Practices of Kosterman Chiropractic.

I am aware that Kosterman Chiropractic has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all Protected Health Information that it maintains.

____
Patient's Name (Print)

If signed by a representative of the patient:

____
Representative's Name (Print)

____
Relationship to Patient

______________________________ ____________
Patient's/Representative's Signature Date

OFFICE USE ONLY

______________________________ ____________
Authorized Facility Signature Date

Good faith effort to obtain receipt: (Describe)

____

____

____

Rev 080103
Form 03.501

All patients should complete this page

Frank E. Kosterman, D.C.
Timothy M. Kosterman, D.C.

KOSTERMAN CHIROPRACTIC CENTER

"Good Health for Life"

401 Cooper Drive
Clinton, North Carolina 28328
(910) 592-2250 • Fax (910) 592-6149
www.spinaldoc.org

I HAVE NOTIFIED KOSTERMAN CHIROPRACTIC CENTER OF MY CURRENT MEDICAL INSURANCE AND MAILING ADDRESS.

MY PREFERED CONTACT PHONE NUMBER IS__________________.

MY MEDICAL INFORMATION MAY BE SHARED WITH__________ ________________________(NAME/RELATIONSHIP).

I AM AWARE OF THE NOTICE OF PRIVACY PRACTICES OF KOSTERMAN CHIROPRACTIC CENTER LOCATED IN THE PATIENT WAITING ROOM.

I WILL ALLOW THE FOLLOWING PEOPLE TO INQUIRE ABOUT MY APPOINTMENT TIMES AND THEY CAN BE GIVEN SUCH INFORMATION BY EMPLOYEES OF KOSTERMAN CHIROPRACTIC CENTER.

1.__________________________________
2.__________________________________
3.__________________________________
4.__________________________________

PATIENT/GUARDIAN
SIGNATURE________________________**DATE**______________
PRINT NAME____

Female patients should skip to page 10 - Male patients should complete pages 7, 8 & 9

Is it okay to call you at work?

☐ Yes ☐ No

How did you hear about our clinic? Or who referred you?

☐ Family member ☐ Attorney ☐ Internet web site ☐ Health class
☐ Friend ☐ Yellow Pages ☐ Billboard ☐ Brochure
☐ Physician ☐ Newspaper ad ☐ TV Commercial ☐ Direct mail ad
☐ Employer ☐ Sign on building ☐ Radio ☐ Other

If you selected 'Yellow Pages' please indicate which Yellow Pages:

__________ __________ __________ __________

If you selected 'family member', 'friend', or 'physician' please enter their name below:

____

If you selected 'other' please describe

____

Medical Conditions:

☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart Disease
☐ Hypertension ☐ Psychiatric Illness ☐ Skin Disorder ☐ Stroke
☐ Other __________ ☐ Other __________

Surgeries:

☐ Appendectomy ☐ Cardiovascular procedure ☐ Cervical disc procedure ☐ Hysterectomy
☐ Joint replacement ☐ Laminectomies ☐ Radical prostatectomy ☐ Transurethral prostate surgery
☐ Other __________ ☐ Other __________

Allergies:

☐ Eggs ☐ Fish and Shellfish ☐ Milk or Lactose ☐ Peanut
☐ Soy ☐ Sulfites ☐ Wheat/Gluten ☐ Other __________

Social History:

☐ Caffeine used occasionally ☐ Caffeine used often ☐ Chew tobacco occasionally ☐ Chew tobacco often
☐ Drink alcohol occasionally ☐ Drink alcohol often ☐ Exercise not at all ☐ Exercise occasionally
☐ Exercise often ☐ Experience stress occasionall ☐ Experience stress often ☐ Smoke 1 pack or less per day
☐ Smoke more than 1 pack a day ☐ Wear seat belts always ☐ Wear seat belts never ☐ Wear seatbelts usually

Family History:

☐ Arthritis (parent) ☐ Arthritis (sibling) ☐ Cancer (parent) ☐ Cancer (sibling)
☐ Cholesterol (parent) ☐ Cholesterol (sibling) ☐ Diabetes (parent) ☐ Diabetes (sibling)
☐ Heart problems (parent) ☐ Heart problems (sibling) ☐ High blood pressure (parent) ☐ High blood pressure (sibling)
☐ Psychiatric (parent) ☐ Psychiatric (sibling) ☐ Stroke (parent) ☐ Stroke (sibling)
☐ Thyroid (parent) ☐ Thyroid (sibling) ☐ Other __________

Substance Use:

☐ Alcohol (past) ☐ Alcohol (present) ☐ Amphetamines (past) ☐ Amphetamines (present)
☐ Barbiturates (past) ☐ Barbiturates (present) ☐ Cocaine (past) ☐ Cocaine (present)
☐ Crystal Meth (past) ☐ Crystal Meth (present) ☐ Heroine (past) ☐ Heroine (Present)
☐ Marijuana (past) ☐ Marijuana (present) ☐ Other __________

Male Children:

☐ Under 6 years ☐ Under 10 years ☐ Under 19 years

Female Children:

☐ Under 6 years ☐ Under 10 years ☐ Under 19 years

Occupational Activities:

☐ Administration ☐ Business owner ☐ Clerical/secretarial ☐ Computer user
☐ Construction ☐ Daycare/childcare ☐ Executive/legal ☐ Food service industry
☐ Health care ☐ Heavy equipment operator ☐ Heavy manual labor ☐ Home services
☐ Household ☐ Light manual labor ☐ Manufacturing ☐ Medium manual labor
☐ Household ☐ Light manual labor ☐ Manufacturing ☐ Medium manual labor

Female patients should skip to page 10 - Male patients should complete pages 7, 8 & 9

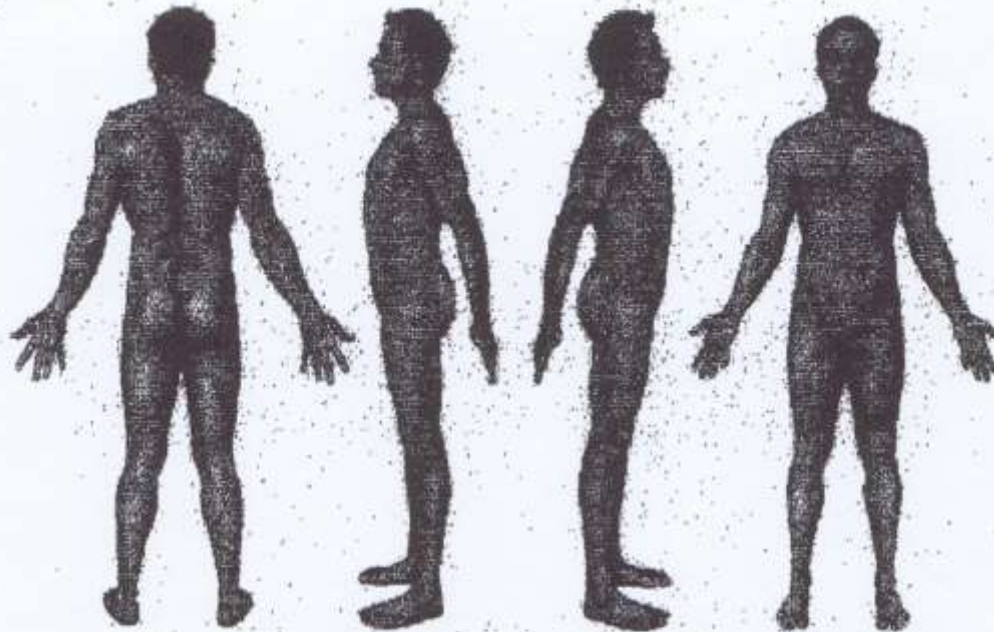
❑ Military ❑ Police/fire ❑ Professional Service ❑ Teacher
❑ Truck driver ❑ Other ____________________

Recreational Activities:

❑ Backpacking	❑ Biking	❑ Boating	❑ Football
❑ Golf	❑ Racket ball	❑ Rock climbing	❑ Running
❑ Skiing	❑ Soccer	❑ Swimming	❑ Tennis
❑ Walking	❑ Weight lifting	Other ____________	

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

 # = Numbness X = Burning / = Stabbing 0 = Pins & Needles + = Dull Ache



Describe your symptoms:____

____

When did your symptoms start? Month__________ **Day**__________ **Year**__________

How did your symptoms begin?____

____

How often do you experience your symptoms?

❑ Constantly (76-100% of the day)	❑ Frequently (51-75% of the day)	❑ Occasionally (26-50% of the day)	❑ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

❑ Sharp	❑ Dull ache	❑ Numb	❑ Shooting
❑ Burning	❑ Tingling	❑ Stabbing	

How are your symptoms changing?

❑ Getting better ❑ Not changing ❑ Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

❑ 0 None ❑ 1 ❑ 2 ❑ 3

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Female patients should skip to page 10 - Male patients should complete pages 7, 8 & 9

- ❑ 4 ❑ 5 ❑ 6 ❑ 7
- ❑ 8 ❑ 9 ❑ 10 Unbearable

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):
❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit
❑ Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?
❑ All of the time ❑ Most of the time ❑ Some of the time ❑ A little of the time
❑ None of the time

In general, would you say your overall health right now is....
❑ Excellent ❑ Very good ❑ Good ❑ Fair
❑ Poor

Who have you seen for your symptoms:
❑ No one ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist
❑ Other ____________________

What treatment did you receive for your symptoms?
❑ Adjustments ❑ Physical Therapy ❑ Medication ❑ Surgery
❑ Other ____________________

When did you receive this treatment?
❑ In the last month ❑ 2 – 3 months ago ❑ 3 – 6 months ago ❑ 6 months to 1 year ago
❑ 1 – 2 years ago ❑ 2 – 5 years ago ❑ 5 – 10 years ago

What tests have you had for your symptoms?
❑ X-rays ❑ MRI ❑ CT Scan ❑ Other

When were these tests done?
❑ In the last month ❑ 2 – 3 months ago ❑ 3 – 6 months ago ❑ 6 months to 1 year ago
❑ 1 - 2 years ago ❑ 2 – 5 years ago ❑ 5 – 10 years ago

Have you had similar symptoms in the past?
❑ Yes ❑ No

If you have seen treatment in the past for the same or similar symptoms, who did you see?
❑ This Office ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist
❑ Other ____________________

What is your occupation?
❑ Professional/Executive ❑ White Collar/Secretarial ❑ Tradesperson ❑ Laborer
❑ Homemaker ❑ Full-time Student ❑ Retired ❑ Other

If you are not retired, a homemaker or a student, what is your work status?
❑ Full-time ❑ Part-time ❑ Self-employed ❑ Unemployed
❑ Off work ❑ Other ____________________

Thank you. Please return to the front desk.

Created 7/31/07

Female patients should complete pages 10, 11 & 12

Is it okay to call you at work?

- ☐ Yes
- ☐ No

How did you hear about our clinic? Or who referred you?

- ☐ Family member
- ☐ Friend
- ☐ Physician
- ☐ Employer
- ☐ Attorney
- ☐ Yellow Pages
- ☐ Newspaper ad
- ☐ Sign on building
- ☐ Internet web site
- ☐ Billboard
- ☐ TV Commercial
- ☐ Radio
- ☐ Health class
- ☐ Brochure
- ☐ Direct mail ad
- ☐ Other

If you selected 'Yellow Pages' please indicate which Yellow Pages:

______________ ______________ ______________ ______________

If you selected 'family member', 'friend', or 'physician' please enter their name below:

____

If you selected 'other' please describe

____

Medical Conditions:

- ☐ Arthritis
- ☐ Hypertension
- ☐ Cancer
- ☐ Psychiatric illness
- ☐ Diabetes
- ☐ Skin Disorder
- ☐ Heart Disease
- ☐ Stroke

Surgeries:

- ☐ Appendectomy
- ☐ Joint replacement
- ☐ Cardiovascular procedure
- ☐ Laminectomies
- ☐ Cervical disc procedure
- ☐ Radical prostatectomy
- ☐ Hysterectomy
- ☐ Transuretheral prostate surgery

Allergies:

- ☐ Eggs
- ☐ Soy
- ☐ Fish and Shellfish
- ☐ Sulfites
- ☐ Milk or Lactose
- ☐ Wheat/Gluten
- ☐ Peanut

Social History:

- ☐ Caffeine used occasionally
- ☐ Drink alcohol occasionally
- ☐ Exercise often
- ☐ Smoke more than 1 pack a day
- ☐ Caffeine used often
- ☐ Drink alcohol often
- ☐ Experience stress occasionall
- ☐ Wear seat belts always
- ☐ Chew tobacco occasionally
- ☐ Exercise not at all
- ☐ Experience stress often
- ☐ Wear seat belts never
- ☐ Chew tobacco often
- ☐ Exercise occasionally
- ☐ Smoke 1 pack or less per day
- ☐ Wear seatbelts usually

Family History:

- ☐ Arthritis (parent)
- ☐ Cholesterol (parent)
- ☐ Heart problems (parent)
- ☐ Psychiatric (parent)
- ☐ Thyroid (parent)
- ☐ Arthritis (sibling)
- ☐ Cholesterol (sibling)
- ☐ Heart problems (sibling)
- ☐ Psychiatric (sibling)
- ☐ Thyroid (sibling)
- ☐ Cancer (parent)
- ☐ Diabetes (parent)
- ☐ High blood pressure (parent)
- ☐ Stroke (parent)
- ☐ Cancer (sibling)
- ☐ Diabetes (sibling)
- ☐ High blood pressure (sibling)
- ☐ Stroke (sibling)

Substance Use:

- ☐ Alcohol (past)
- ☐ Barbiturates (past)
- ☐ Crystal Meth (past)
- ☐ Marijuana (past)
- ☐ Alcohol (present)
- ☐ Barbiturates (present)
- ☐ Crystal Meth (present)
- ☐ Marijuana (present)
- ☐ Amphetamines (past)
- ☐ Cocaine (past)
- ☐ Heroine (past)
- ☐ Amphetamines (present)
- ☐ Cocaine (present)
- ☐ Heroine (Present)

Male Children:

- ☐ Under 6 years
- ☐ Under 10 years
- ☐ Under 19 years

Female Children:

- ☐ Under 6 years
- ☐ Under 10 years
- ☐ Under 19 years

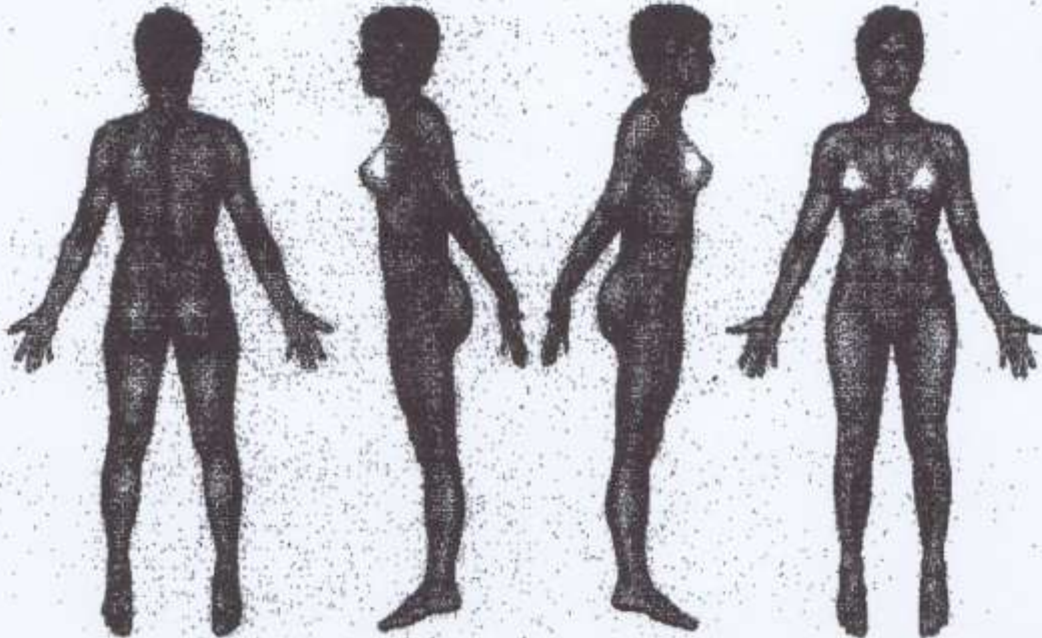
Occupational Activities:

- ☐ Administration
- ☐ Construction
- ☐ Health care
- ☐ Household
- ☐ Business owner
- ☐ Daycare/childcare
- ☐ Heavy equipment operator
- ☐ Light manual labor
- ☐ Clerical/secretarial
- ☐ Executive/legal
- ☐ Heavy manual labor
- ☐ Manufacturing
- ☐ Computer user
- ☐ Food service industry
- ☐ Home services
- ☐ Medium manual labor

Female patients should complete pages 10, 11 & 12

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

 # = Numbness **X = Burning** **/ = Stabbing** **0 = Pins & Needles** **+ = Dull Ache**



Describe your symptoms:____

____

When did your symptoms start? **Month**____________ **Day**____________ **Year**____________

How did your symptoms begin?____

____

How often do you experience your symptoms?

- ❑ Constantly (76-100% of the day)
- ❑ Frequently (51-75% of the day)
- ❑ Occasionally (26-50% of the day)
- ❑ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- ❑ Sharp
- ❑ Dull ache
- ❑ Numb
- ❑ Shooting
- ❑ Burning
- ❑ Tingling
- ❑ Stabbing

How are your symptoms changing?

- ❑ Getting better
- ❑ Not changing
- ❑ Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

- ❑ 0 None
- ❑ 1
- ❑ 2
- ❑ 3
- ❑ 4
- ❑ 5
- ❑ 6
- ❑ 7
- ❑ 8
- ❑ 9
- ❑ 10 Unbearable

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):

- ❑ Not at all
- ❑ A little bit
- ❑ Moderately
- ❑ Quite a bit
- ❑ Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

- ❑ All of the time
- ❑ Most of the time
- ❑ Some of the time
- ❑ A little of the time
- ❑ None of the time

Created 7/31/07

Female patients should complete pages 10, 11 & 12

☐ 4 ☐ 5 ☐ 6 ☐ 7
☐ 8 ☐ 9 ☐ 10 Unbearable

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit
☐ Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?
☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time
☐ None of the time

In general, would you say your overall health right now is....
☐ Excellent ☐ Very good ☐ Good ☐ Fair
☐ Poor

Who have you seen for your symptoms:
☐ No one ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist
☐ Other ______________________

What treatment did you receive for your symptoms?
☐ Adjustments ☐ Physical Therapy ☐ Medication ☐ Surgery
☐ Other ______________________

When did you receive this treatment?
☐ In the last month ☐ 2 – 3 months ago ☐ 3 – 6 months ago ☐ 6 months to 1 year ago
☐ 1 – 2 years ago ☐ 2 – 5 years ago ☐ 5 – 10 years ago

What tests have you had for your symptoms?
☐ X-rays ☐ MRI ☐ CT Scan ☐ Other

When were these tests done?
☐ In the last month ☐ 2 – 3 months ago ☐ 3 – 6 months ago ☐ 6 months to 1 year ago
☐ 1 - 2 years ago ☐ 2 – 5 years ago ☐ 5 – 10 years ago

Have you had similar symptoms in the past?
☐ Yes ☐ No

If you have seen treatment in the past for the same or similar symptoms, who did you see?
☐ This Office ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist
☐ Other ______________________

What is your occupation?
☐ Professional/Executive ☐ White Collar/Secretarial ☐ Tradesperson ☐ Laborer
☐ Homemaker ☐ Full-time Student ☐ Retired ☐ Other

If you are not retired, a homemaker or a student, what is your work status?
☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed
☐ Off work ☐ Other ______________________

Thank you. Please return to the front desk.