CAROLINA FAMILY CHIROPRACTIC

New Patient Intake Form

Title: __ Mr. __Mrs. __ Ms. __Dr. __ Other Date:_____

Full First Name:_____ Middle Initial: _____ Last Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____

Cell Phone: _____ Email:_____

Date of Birth:_____/_____/_____ Sex: __Male __ Female SSN:_____-_____-_____

Marital Status: __ Single __Married __Other_____

Employment Status: __Employed __Unemployed __FT Student __PT Student __Other_____

Employer Data:

Employer:_____

Occupation:_____ Job Description:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Spouse Data:

Full First Name:_____ Middle Initial: _____ Last Name:_____

Emergency Contact:

Name:_____ Relationship:_____

Cell Phone:_____ Home Phone:_____

How Did You Hear About Us?_____

Dr. Initials_____

Review of Symptoms: check all that apply

Cardiovascular				Respiratory				Allergic			
	Past	*Present*	*No*		*Past*	*Present*	*No*		*Past*	*Present*	*No*
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short of Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pains				Cough							
High Cholesterol				Wheezing							
Pace Maker											
Jaw Pain				Eyes				Ear/Nose/Throat			
Irregular Heartbeat					*Past*	*Present*	*No*		*Past*	*Present*	*No*
Swelling of Legs				Glaucoma				Difficulty Swallowing			
				Double Vision				Dizziness			
Genitourinary				Blurred Vision				Hearing Loss			
	Past	*Present*	*No*					Sore Throat			
Kidney Disease				Psychiatric				Nosebleeds			
Burning Urination					*Past*	*Present*	*No*	Bleeding Gums			
Frequent Urination				Depression				Sinus Infection			
Blood in Urine				Anxiety							
Kidney Stones				Stress				Gastrointestinal			
Lower Side Pain									*Past*	*Present*	*No*
				Endocrine				Gall Bladder			
Neurologic					*Past*	*Present*	*No*	Bowel Problems			
	Past	*Present*	*No*	Thyroid				Constipation			
Stroke				Diabetes				Liver Problems			
Seizures				Hair Loss				Ulcers			
Head Injury				Menopause				Diarrhea			
Brain Aneurysm				Menstrual				Nausea/Vomiting			
Numbness								Bloody Stool			
Severe Headaches				Hematologic				Poor Appetite			
Pinched Nerves					*Past*	*Present*	*No*				
Parkinson's				Hepatitis				Musculoskeletal			
Carpal Tunnel				Blood Clots					*Past*	*Present*	*No*
Vertigo				Cancer				Gout			
				Bruising				Arthritis			
Constitutional				Bleeding				Joint Stiffness			
	Past	*Present*	*No*	Fever, Chills				Muscle Weakness			
Weight Loss/Gain				Sweating				Osteoporosis			
Low Energy								Broken Bones			
								Joint Replacement			

Dr. Initials_____

Check all that apply

Medical Conditions			Surgeries			Social History			
	Yes	No		Yes	No		Occasional	Often	Never
Arthritis			Appendectomy			Caffeine			
Cancer			Cardiovascular			Alcohol			
Diabetes			Hysterectomy			Chew Tobacco			
Heart Disease			Joint Replacement			Smoke			
Hypertension			Prostate						
Psychiatric Illness			Cervical Spine			Family History			
Skin Disorder			Thoracic Spine				Parent	Sibling	
Stroke			Lumbar Spine			Arthritis			
Other			Gall Bladder			Cancer			
			Brain			Diabetes			
			Shoulder			Heart Disease			
			Carpal Tunnel			Stroke			
			Gastro-Intestinal			Thyroid			
			Knee			Other			
			Hernia						

Wear Seat Belts: __ occasional __ always __ never

Hobbies/Interests _____

List any **Medications** you are taking:_____

How did the pain start: _____

_____

Dr. Initials_____

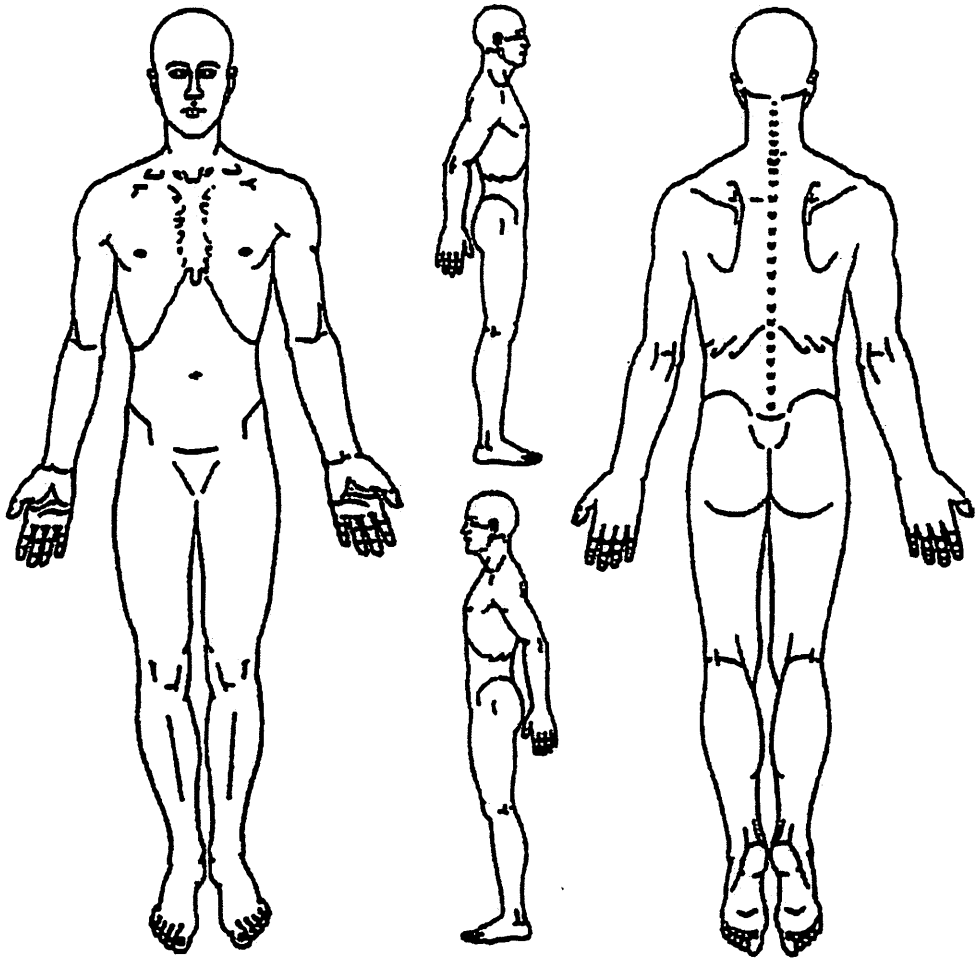
Please Rate Your Pain On a Scale of 1-10, with 10 being the worst

1 2 3 4 5 6 7 8 9 10

Are you Pregnant? Yes No

Use the Drawing Below to Mark Your Areas of Pain:

N= Numbness B= Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1.

1-_____ 2-_____

3-_____ 4-_____

When did symptoms begin? Month_____ Day_____ Year_____

Result of : __ Motor Vehicle Accident __Work Related __Other_____

Getting: __Better __Worse __Staying the Same

Dr. Initials_____

Functional Pain Index

For each item below, please circle the one choice that most closely describes your condition right now.

1.	Pain Intensity:	no pain	mild pain	moderate pain	severe pain	worst pain
2.	Sleeping:	perfect sleep	mildly disturbed	moderately disturbed	greatly disturbed	totally disturbed
3.	Personal care:	no pain	mild pain no restrictions	moderate pain, go slow	moderate pain, needs help	severe pain 100% help
4.	Travel:	no pain on long trip	mild pain on long trip	moderate pain on long trip	moderate pain on *short* trip	severe pain on *short* trip
5.	Work:	can do usual work plus extra	can do usual work no extra	can do 50 % of work	can do 25% of work	cannot work
6.	Recreation:	no pain	mild pain	moderate pain	severe pain	worst pain
7.	Frequency of Pain:	no pain	occssional pain, 25 % of day	intermittent pain, 50 % of day	frequent pain, 75 % of day	constant 100% of day
8.	Lifting:	no pain w/ heavy wt	increased pain w/ heavy wt	increased pain w/ heavy wt	increased pain w/ *light* wt	increased pain w/ any wt
9.	Walking:	no pain any distance	increased pain after 1 mi	increased pain after ½ mi	increased pain after ¼ mi	increased pain after all walking
10.	Standing:	no pain	increased pain after several hrs	increased pain after 1 hr	increased pain after ½ hr	increased pain after any standing

What is your current pain level: 1 2 3 4 5 6 7 8 9 10

What improvements do you have, since start of care:_____

Name:_____ **Date:**_____

Dr Initails: _____

HIPPA Privacy Practices

I acknowledge that I have received and/or have been given the opportunity to review Carolina Family Chiropractic's Notice of HIPPA Privacy Practices for protected health information.

The statements made on this form are accurate to the best of my knowledge and I agree to allow this office to examine me for further evaluation.

I further authorize Carolina Family Chiropractic to release any information needed to complete claims to my health insurance and/or attorney.

In order to maximize your care, we would like your permission to keep your PCP up to date about your care and progress:

I (*would*) (*would not*) also like to have periodic update sent to my PCP. _____ Initials

Dr._____

Address _____

Print Patient Name_____ Signature_____

Date:_____

Consent to Treat a Minor (Name)_____ Signature_____

Guardians Signature Authorizing Care_____

Informed Consent Form (please read before signing)

The Nature of Chiropractic Adjustment

The primary treatment I use as Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "click' or "pop", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, treatment you are consenting to the following:

Spinal Manipulative Therapy, Range of Motion testing, Orthopedic testing, Basic neurologic testing, Muscle strength testing, Postural analysis, Electrical stimulation, Ultrasound, Hot/cold therapy, Radiographic studies, Mechanical traction, Decompression, Acupuncture.

The material risks inherent in chiropractic adjustment:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck contributing to serious complications. Some patients will feel stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care, however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

Dr. Initials_____

The Probability of those risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidence of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments The other complications are also generally described as rare.

The availability and nature of other treatment options:

Other treatment options for your conditions may include: Self administered, over the counter analgesics and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers, hospitalization, and surgery.

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this progress may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I hereby authorize and direct you, the insurance company, and/or my attorney, to pay directly to Carolina Family Chiropractic such sums that may be due and owing this office for services rendered to me, both by reason of accident, of illness and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workmens' compensation benefits, or any other insurance benefits obligated reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office.

I hereby further give a lien to said office against any and all insurance named herein, and any and all proceeds of any settlement, judgment or verdict that may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for their services.

I further understand and agree that this assignment, lien and authorization does not contribute any consideration for the office to await payments and they may demand payment from me upon rendering services at their option. I authorize this office to release any information pertinent to my case to any insurance company or attorney to facilitate collection under this assignment, lien and authorization.

I agree that the above mentioned office be given power of attorney to endorse my name on any and all checks for payment of my doctor bill.

I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and reimburse this office for all costs of such collection efforts including but not limited to all court costs and attorney fees.

I fully understand that upon settlement, by signing this agreement and without exception, I cannot use G.S. 44.49, Supplement or G.S. 44.50. The above general statutes mention recoveries for personal injury. I acknowledge my acceptance by my signature, which is witnessed and notarized to waive use of the above general statutes. Please acknowledge this letter by signing below.

I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payments on my current balance.

I have read ( ) or had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name_____ Date_____

Patient/Guardian Signature_____ Doctor Signature_____