

REGISTRATION

Date: _____ Home Phone: _____ Cell: _____
 Name: _____ Social Security #: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Gender: Male / Female
 Occupation: _____ Employer: _____ Work Phone #: _____
 Marital Status: _____ Number of Children: _____ How old are they? _____
 Are you a student? Y N Where? _____ Grade Level: _____
 Referred to this office by: _____ e-mail: _____
 Have you ever been treated by a chiropractor before? Y N When? _____ Why? _____
 Emergency contact (Name and Phone #): _____

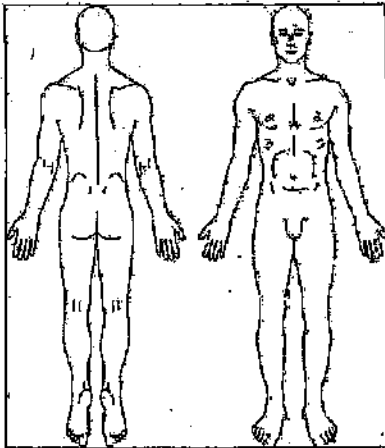
Present Complaints (Please circle ALL that apply)

Headache	Feet/Hands Cold	Unbalanced
Mental dullness	Depression	Fainting
Loss of memory	Rib pain	Blurred vision
Dizzy	Nervousness	Irritability
Ears ringing/buzzing	Eye strain/pain	Double vision
Upper back pain	Shortness of breath	Loss of smell
Lower back pain	Fear	Chest pain
Midback pain	Confusion	Neck pain
Pins and needles in hands right/left	Pins and needles in arms right/left	Pins and needles in legs right/left

Medical Implants: _____ Medical alerts: _____
 Surgical Implants: _____ Pregnancy: yes _____ no _____

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain
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Please circle the areas where you have symptoms on the diagram to the left. Make note of the character of the symptoms using the following abbreviations. Circle all that apply.

S= Sharp **D**= Dull **A**=Achy **N**=Numb **T**=Tingling **B**= Burning

How frequent do you notice your symptoms (circle one):
 Constant Frequent Intermittent Occasional

What makes it feel worse: _____
 What makes it feel better: _____
 When did this condition first appear? _____
 What do you think caused it? _____

Please circle any of the following CHANGES since the onset of your condition:

Bowel Issues Bladder Issues Fever Night Sweats Weight Loss Explain: _____

Medications: (please list all medications and supplements that you currently take)

Allergies: (please list all medications that cause allergic reaction)

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____ Date _____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

NO MEDICAL PROBLEMS - no prior history of any significant medical problems

Lungs / Pulmonary - breathing disorders

- asthma
- COPD
- emphysema
- pulmonary embolism
- pneumonia
- tuberculosis
- respiratory arrest
- sleep apnea
- other: _____

Cardiac / Heart and peripheral vascular disease

- chest pain / angina
- heart attack, myocardial infarction
- congestive heart failure
- other: _____
- high blood pressure
- heart murmur, valve disorder
- mitral valve prolapse
- bleeding problems
- irregular heartbeat, arrhythmia
- peripheral vascular disease
- deep vein thrombosis

Neurologic Disorders

- stroke or TIA
- peripheral neuropathy
- other: _____
- parkinson's
- MS
- cerebral palsy
- polio

Bone & Joint Disorders

- osteoarthritis
- rheumatoid arthritis
- other: _____
- gout
- lupus
- osteomyelitis
- ankylosing spondylitis

Gastrointestinal Disorders

- peptic ulcer or stomach ulcer
- acid reflux, GERD
- GI bleed
- diverticulitis
- Irritable bowel
- Inflammatory bowel disease
- hepatitis - Type _____
- liver disease
- other: _____

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

- Medicare Blue Cross/Shield Auto Accident
- Cigna Aetna Union Plan
- United Health Worker's Compensation Other

Insurance Group Number: _____

Insurance Identification Number: _____

Medicare Identification Number: _____

Primary Care Physician:

Name: _____

Address: _____

Phone #: _____

Major Medical or Auto Insurance:

Date of Accident: _____

Insurance Company Name: _____

Adjuster: _____

Address/Phone: _____

Claim #: _____ Policy #: _____ Effective Date: _____

LEGAL INFORMATION:

Attorney Name: _____

Attorney Address: _____

Attorney Phone #: _____

**Patient Agreement:
ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance coverage with _____
(Name of Insurance Company)
 and assign directly to Dr. David Wright, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian Date

Central Chiropractic & Sports Medicine

611 N Central Ave. • Belmont • NC • 28012

Phone: 704-829-9200 • Fax: 704-829-5700

Authorization & Releases

Patient Name: _____

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physio-therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Central Chiropractic & Sports Medicine and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working, or associated with, or serving as back-up for Central Chiropractic & Sports Medicine, including those working at the clinic or office listed or any other office or clinic.

I have had an opportunity to discuss with the doctor named below and/or with other office/clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand that the doctor(s) do not offer to diagnose or treat any condition or disease other than vertebral subluxation, nor do they offer advice regarding treatment prescribed by others. However, if during the course of a chiropractic examination, abnormal or unusual findings outside the scope of chiropractic are discovered, the doctor will advise me and make the most appropriate referral.

I understand I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure(s) which the doctor feels, at the time, based upon the facts then known, is in my best interests. I understand that all adjustments are made in the open suite and that if I require private consultation with the doctor, I can arrange that with the front desk staff at any time during normal office hours.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent, and by signing below I agree to the above-named procedures, I intend this consent form to cover the entire course of treatment for my present conditions and for any future condition(s) for which I seek treatment.

Patient Signature _____ Dependent's Name _____ Date _____

Doctor Signature _____ Date _____

Authorization to Release Medical Records

I authorize the release of any medical information necessary to process my case and/or insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient Signature _____ Date _____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the doctors and/or associates of Central Chiropractic & Sports Medicine have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____

Patient Signature: _____ Date: _____

Central Chiropractic & Sports Medicine's Notice of Privacy for: Patient's Protected Health Information

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Workers Compensation Claim to verify that treatment has been rendered.
- To determine patient's benefits in a health care plan.
- Releasing information required by State and Federal Public Health Law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurance for your privacy have been attained.
- Emergency situations.
- Abuse, neglect, or domestic violence.
- Appointment reminders to household members or answering machines.
- Sign-In logs may be disclosed to verify office visits.

Any other uses or disclosures will only be made with your specific written prior authorization.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer who is: Susan Wright and can be reached at: 704-829-9200 regarding privacy issues.
- Inspect, copy, and amend your protected health information.
- Obtain our accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer or the Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

Name of Patient (Please Print)

Signature of Patient/Legal Representative

Date

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ① The pain comes and goes and is very mild.
- ② The pain is mild and does not vary much.
- ③ The pain comes and goes and is moderate.
- ④ The pain is moderate and does not vary much.
- ⑤ The pain comes and goes and is very severe.
- ⑥ The pain is very severe and does not vary much.

Sleeping

- ① I get no pain in bed.
- ② I get pain in bed but it does not prevent me from sleeping well.
- ③ Because of pain my normal sleep is reduced by less than 25%.
- ④ Because of pain my normal sleep is reduced by less than 50%.
- ⑤ Because of pain my normal sleep is reduced by less than 75%.
- ⑥ Pain prevents me from sleeping at all.

Sitting

- ① I can sit in any chair as long as I like.
- ② I can only sit in my favorite chair as long as I like.
- ③ Pain prevents me from sitting more than 1 hour.
- ④ Pain prevents me from sitting more than 1/2 hour.
- ⑤ Pain prevents me from sitting more than 10 minutes.
- ⑥ I avoid sitting because it increases pain immediately.

Standing

- ① I can stand as long as I want without pain.
- ② I have some pain while standing but it does not increase with time.
- ③ I cannot stand for longer than 1 hour without increasing pain.
- ④ I cannot stand for longer than 1/2 hour without increasing pain.
- ⑤ I cannot stand for longer than 10 minutes without increasing pain.
- ⑥ I avoid standing because it increases pain immediately.

Walking

- ① I have no pain while walking.
- ② I have some pain while walking but it doesn't increase with distance.
- ③ I cannot walk more than 1 mile without increasing pain.
- ④ I cannot walk more than 1/2 mile without increasing pain.
- ⑤ I cannot walk more than 1/4 mile without increasing pain.
- ⑥ I cannot walk at all without increasing pain.

Personal Care

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ② I do not normally change my way of washing or dressing even though it causes some pain.
- ③ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ④ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ⑤ Because of the pain I am unable to do some washing and dressing without help.
- ⑥ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor.
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ⑤ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑥ I can only lift very light weights.

Traveling

- ① I get no pain while traveling.
- ② I get some pain while traveling but none of my usual forms of travel make it worse.
- ③ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ④ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ⑤ Pain restricts all forms of travel except that done while lying down.
- ⑥ Pain restricts all forms of travel.

Social Life

- ① My social life is normal and gives me no extra pain.
- ② My social life is normal but increases the degree of pain.
- ③ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ④ Pain has restricted my social life and I do not go out very often.
- ⑤ Pain has restricted my social life to my home.
- ⑥ I have hardly any social life because of the pain.

Changing degree of pain

- ① My pain is rapidly getting better.
- ② My pain fluctuates but overall is definitely getting better.
- ③ My pain seems to be getting better but improvement is slow.
- ④ My pain is neither getting better or worse.
- ⑤ My pain is gradually worsening.
- ⑥ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

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Score

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

Sleeping

- Ⓐ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- Ⓐ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

Concentration

- Ⓐ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

Work

- Ⓐ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

Personal Care

- Ⓐ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

Driving

- Ⓐ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

Recreation

- Ⓐ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Headaches

- Ⓐ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Neck
Index
Score

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100