CAROLINA CHIROPRACTIC *Plus*

Patient Data: **Date:** _____

Title: (Check one) __Mr. __Mrs. __Ms. __ Miss. __ Dr. __ Other _____

Full Name _____

Preferred to be called _____

Address Line 1 _____

Address Line 2 _____

City _____ **State**_____ **Zip Code**_____

Home Phone (_____) _____-_____**Work** (____) _____-_____

Cell (____) _____-_____ **Email** _____

Best Point of Contact? (Please circle) Home Work Cell Email

Date of Birth ____/____/_____ **Age**___ **Sex:** Male ___Female___ Other _____

Social Security Number _____-____-_____ **Marital Status:** Single__Married__Other__

Referral Source _____

Employment Status:

Employed By: _____

Address_____

City_____ **State**_____ **Zip Code** _____

Spouse Data:

Is your spouse as patient in the clinic? __Yes __ No

Full Name _____

Spouse's Date of Birth ___/____/____ **Spouse's SS#:** _____-___-_____

Are they the policy holder? __ Yes __ No **If yes, complete the below:**

Employed By: _____

Address_____

City_____ **State**_____ **Zip Code** _____

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Emergency Contact:

Contact Name /Relation_____

Contact Phone Number _____

Medical Conditions:

Please check any condition you have or have had. ☐No medical history to report

☐Allergies ☐Anemia ☐Anxiety ☐Arthritis ☐Asthma ☐Blood transfusion ☐Cancer ☐Congestive Heart Failure ☐Nerve/Muscle Disease ☐Lung disease ☐Meningitis ☐Depression ☐HIV/AIDS ☐Kidney Disease ☐Diabetes mellitus ☐Clotting Disorder (blood clot) ☐High Blood Pressure ☐Acid Reflux ☐Glaucoma ☐Gout ☐Heart Attack ☐High Cholesterol ☐Osteoporosis ☐Seizures ☐Sickle Cell Anemia ☐Stroke ☐Substance Abuse ☐Thyroid disease ☐Tuberculosis ☐Ulcers ☐Anesthetic Complications ☐Cataracts ☐Other:

_____

Past Surgical History

Please check any surgery you have had. ☐Never had surgery

☐Appendix ☐Brain Surgery ☐Breast Surgery ☐Open Heart or Bypass Surgery ☐Gall Bladder ☐Colon Surgery ☐Fracture Surgery ☐Hernia Repair ☐C-Section ☐Eye Surgery ☐Hysterectomy ☐Joint Replacement ☐Small Intestine Surgery ☐Spine Surgery ☐Tubes Tied ☐Heart Valve Replacement ☐Cosmetic Surgery ☐Orthopedic Surgery _____ ☐Other:_____

Family History **Please check all that apply**

☐Arthritis (parent/sibling) ☐Cholesterol (parent/sibling) ☐Heart problems (parent/sibling) ☐ Psychiatric (parent/sibling) ☐Thyroid (parent/sibling) ☐ Cancer (parent/sibling)☐ Diabetes (parent/sibling)☐ High Blood Pressure (parent/sibling) ☐Stroke (parent/sibling)

Social History **Please check all that apply**

☐Current Every Day Smoker ☐Current Some Day Smoker ☐Former Smoker, Quit Date_____

☐Never Smoker ☐Passive Smoker (2nd Hand Smoke) ☐Vaping ☐Alcohol: Drinks/week _____ ☐ Drug use: Uses/week _____ ☐Marijuana ☐Cocaine ☐Methamphetamines ☐IV

Recreational Activities **Please check all that apply**

☐Backpacking ☐Golf ☐Soccer ☐Weight Lifting ☐Biking ☐Racket Ball ☐Swimming ☐ Boating ☐Running ☐Tennis ☐ Baseball ☐Football ☐Basketball ☐Running/Walking ☐Skiing

Occupational Activities **Please check all that apply**

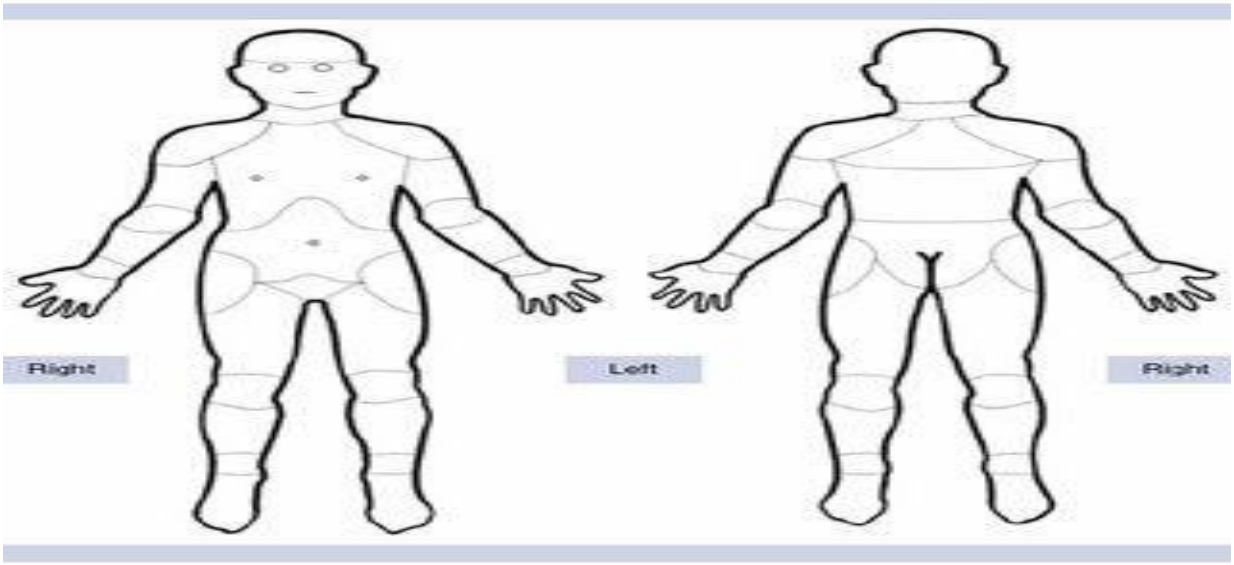
☐ Administration ☐Construction ☐Healthcare ☐Household ☐Business Owner ☐Daycare/childcare ☐Heavy equipment operator ☐ Light manual labor ☐Clerical/secretarial ☐Executive/legal ☐ Heavy manual labor ☐Manufacturing ☐Food services ☐other_____

Patient Signature _____Date_____

Guardian or Spouse's Signature authorizing care_____

CAROLINA CHIROPRACTIC *Plus*

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 best 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 or your symptoms:
(0 = NONE to 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 has pain interfered with your social activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

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

Who have you seen for your symptoms? _____

What treatment(s) have you had for your symptoms?
☐ Adjustments ☐ Physical Therapy ☐ Medication ☐ Surgery ☐ Other

When did you receive the above treatment(s)? _____

What test(s) have you had for your symptoms?
☐ X- rays ☐ MRI ☐ CT scan ☐ Other

When did you receive the above treatment(s)? _____

When were there test(s) done? _____

Have you had similar symptoms in the past? (Circle one) YES or NO

If you have seen treatment in the past for the same or similar symptoms, who did you see?
_____

What is your occupation? _____

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

Who is your primary care physician? _____

Name of the clinic? _____

Would you like for us to communicate with your primary care physician? YES____ NO___
I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that Carolina Chiropractic Plus will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the office will be credited to my account on receipt. I also give the office power attorney to endorse checks made out to me to be credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable.

Patient Signature _____Date_____

Guardian or Spouse's Signature authorizing care_____

CAROLINA CHIROPRACTIC *Plus*

Name_____ Date_____

Outcomes Assessment:

Neck Pain Questionnaire- Check the Box of the answer that most applies to you.

1. Pain Intensity
o The pain come and goes and is very mild
oThe pain is very mild and does not vary much
oThe pain is very Moderate and does not vary much
oThe pain comes and goes and is moderate
oThe pain is very severe and it is severe
oThe pain is severe and does not vary much

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

3. Lifting
oI can lift heavy weights without extra pain
oI can lift heavy weights but it gives extra pain
oPain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned on a table
oPain prevents me from lifting heavy weights but I can manage light to medium wights if they are conveniently positioned
oI can lift very lightweights
oI cannot lift anything at all

4. Reading
oI can read as much as I want with no pain in my neck
oI can read as much as I want with slight pain in my neck
oI can read as much as I want with moderate pain in my neck
oI cannot read as much as I want because of moderate pain in my neck
oI can hardly read at all because of severe pain in neck

5. Headaches
oI have no headache at all
oI have slight headaches, which come infrequently
oI have moderate headaches, which come frequently
oI have severe headaches, which come frequently
oI have headaches almost all the time

6. Concentration
oI can concentrate fully when I want to with no difficulty
oI can concentrate fully when I want to with slight difficulty
oI have a fair degree of difficulty in concentrating when I want to.
oI have a lot of difficulty in concentrating when I want to
oI have a great deal of difficulty in concentrating when I want to
oI cannot concentrate at all

7. Work
oI can do as much work as I want to
oI can only do my usual work, but no more
oI can do most of my usual work, but no more
oI can hardly do any work at all
oI cannot do any work at all

8. Driving
oI can drive without any neck pain
oI can drive as long as I want with slight pain in my neck
oI cannot drive as long as I want because of moderate pain in my neck
oI can hardly drive at all because of severe pain in my neck
oI cannot drive my car at all

9. Sleeping
oI have no trouble sleeping
oMy sleep is slightly disturbed)less than 1 hr sleepless)
oMy sleep is mildly disturbed (1-2 hrs sleepless)
oMy sleep is moderately disturbed (2-3 hrs sleepless)
o My sleep is greatly disturbed (3-5 hrs sleepless)
oMy sleep s completely disturbed (5-7 hrs sleepless)

10. Recreation
oI am able to engage in all my recreation activities with no neck pain at all
oI am able to engage in all my recreation activities with some pain in my neck
o I am able to most but not all my recreation activities because of pain in my neck
o I cannot do any recreation activities at all

Name_____ Date_____

Outcomes Assessment:

Back Pain Questionnaire- Check the Box of the answer

1. Pain Intensity
o The pain come and goes and is very mild
oThe pain is very mild and does not vary much
oThe pain is very Moderate and does not vary much
oThe pain comes and goes and is moderate
oThe pain is very severe and it is severe
oThe pain is severe and does not vary much

6. Standing
oI can stand as long as I want without pain
oI have some pain while standing, but it does not increase with time
oI cannot stand longer then 1 hour without increasing pain
oI cannot stand longer than ½ hour without increasing pain
oI cannot stand longer than 10 minutes without increasing pain
oPain prevents me from sleeping at all

CAROLINA CHIROPRACTIC *Plus*

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I herby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic; Dr Sarah Merrison and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had the opportunity to discuss with Dr Sarah Merrison and/or with other office or clinic personnel the nature and the purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risk to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations and sprains. I do not expect the physician to be able to anticipate and explain all risk and complications. Further, I wish to rely on the physician to exercise judgement during the course of the procedure which the physician feels are in my best interest at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire treatment for my present condition(s) and for any condition(s) for which I seek treatment at Carolina Chiropractic Plus.

Patient Full Name Printed _____

Signature of Patient _____

To be completed by the patient's representative, if necessary
(e.g. if the patient is a minor or is physically or mentally in capacitated.)

Full Name of the Patient: _____

Full Name of Representative/Relation _____

Signature of Representative_____

Date: _____

CAROLINA CHIROPRACTIC *Plus*

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

I hereby direct any and all insurance carriers, attorneys, agencies, governmental department, companies, individuals, and / or legal entitles ("payer"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ("conditions"), to pay directly, and exclusively in the name of Carolina Chiropractic Plus such sums as may be owing to Carolina Chiropractic Plus for charges incurred by me at the Doctor's office because of any of the above referenced reasons.

I further grant contractual lien to Carolina Chiropractic Plus with respect to all of my charges which I have incurred at the Doctor's office applicable to all payers who are paying because of the injuries for which Carolina Chiropractic Plus has treated me. However, I understand that nothing in this Agreement shall be constructed as an election by Carolina Chiropractic Plus to claim protection under any statutory law.

For the purposes of this Agreement, "benefits" shall include, but shall not by limited to, proceed from my settlement, judgment, or verdict as well as any proceeds relating to commercial health or group insurance, disability benefits, workers compensation benefits, medical payments, benefits, personal injury protection, lost wages benefits, lost services benefit, no-fault coverage, uninsured and under insured motorist coverage, third party liability distributions, and any benefits or proceeds payable to me for the purpose stated herein.

I further agree that, in the event a "payer" refuses to pay Carolina Chiropractic Plus as directed in this Assignment, I hereby assign insofar as permitted by law, all of my right, remedies, and causes of action that I might have against such payer to Carolina Chiropractic Plus to the extent of my charges. I hereby assign these rights to Carolina Chiropractic Plus so that the Doctor may prosecute causes of action either in my name, his name, or in the Office's name, and to settle and or otherwise resolve such causes of action as the Doctor sees fit. This agreement in no way gives, transfer or conveys any control of any lawsuit I may have, which caused the injuries for which the Doctor is treating me, to Carolina Chiropractic Plus. Carolina Chiropractic Plus has no right to direct or manage any underlying lawsuit that has caused the injuries for which the Doctor is treating me. In the event that I retain one or more attorneys to represent me in this matter, I direct each attorney to issue a letter of protection to this office regarding any charges that I incur as set forth above. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the express written consent of this office.

I hereby direct my attorney to pay directly to Carolina Chiropractic Plus from any monies recovered on my behalf from any source, amounts to cover the complete balance that I owe Carolina Chiropractic Plus for the treatment that has rendered to me. These amounts are to be paid to Carolina Chiropractic Plus before any monies are disbursed to me. I hereby direct all payers to release to Carolina Chiropractic Plus any information regarding any amount of coverage, the amount paid thus far, and the amount of any outstanding claims.

I understand that I remain personally responsible for the remaining amounts due to Carolina Chiropractic Plus for his services. This agreement does not constitute any consideration for the doctor to await payments and the doctor may demand payments from me immediately upon rendering services at the Doctor’s option. If the Doctor must take any action to collect an outstanding balance on my account, I will be responsible for payments and will reimburse Carolina Chiropractic Plus all costs of such collection efforts, including but not limited to all court cost and all attorney’s fees. I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interest of Carolina Chiropractic Plus and myself, However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason case to be binding on any party hereto, all other portions and provisions of this agreement shall, nevertheless, remain in full force and effect.

Signature of Patient _____

CAROLINA CHIROPRACTIC *Plus*

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations.

We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- · The practice reserves the right to change the privacy policy as allowed by law.
- · The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- · The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- · The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we use your address to contact you with birthday cards, holiday related cards, newsletters and information about treatment alternatives or other health related information? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed:

_____

_____

_____

This consent was signed by: _____ Date: _____

CAROLINA CHIROPRACTIC *Plus*

Courtesy Initial Visit Waiver

I understand and agree that all services rendered today are part of a complimentary or reduced fee offer for information on chiropractic and its benefits for better health. I understand that I am under no obligation to commit to treatment that may be recommended by Carolina Chiropractic Plus, at my Report of Findings visit, but will have the opportunity to make an informed decision on whether or not to choose this treatment option, should mine be considered a chiropractic case.

In the event the doctor determines that chiropractic would be a viable option, recommendations based on my history and evaluation will be made and fully detailed to me, including any fees associated with continued care beyond this particular visit. At that time, I will have the option to deny or accept care.

Any X-rays and records for this visit are for information only and are permanent records of Carolina Chiropractic Plus. I further understand that because I am receiving a courtesy or reduced service, there is a fee to release records/X-rays pertaining to this visit.

Patient Name _____

Patient/Guardian Signature _____

Date _____