



**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** \_\_\_\_\_



**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

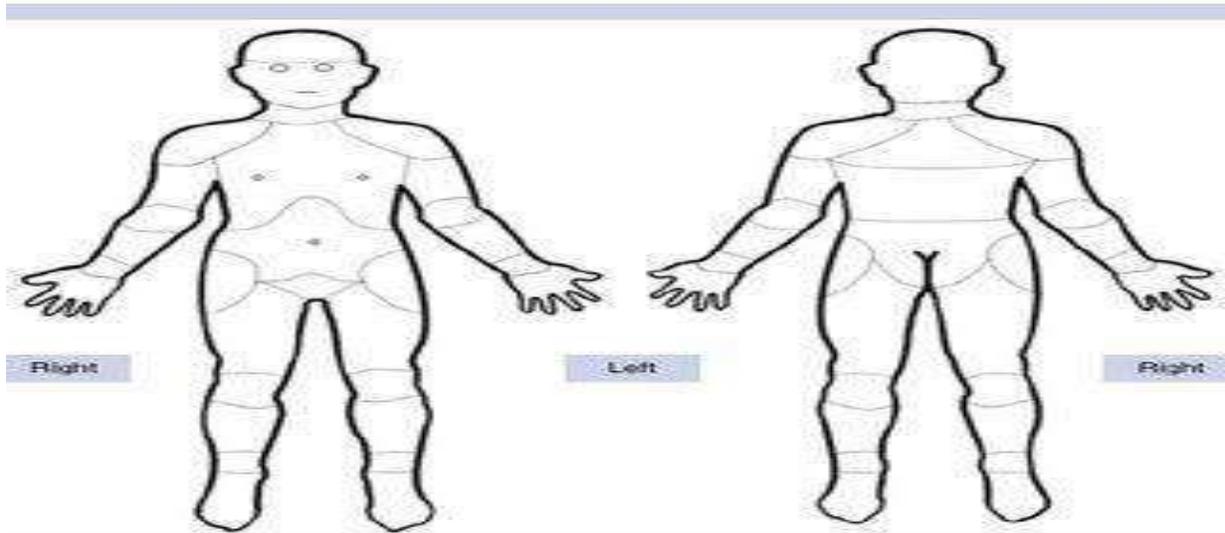
**Occupational Activities**      **Please check all that apply**

- 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 \_\_\_\_\_

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

**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** \_\_\_\_\_



Name \_\_\_\_\_

Date \_\_\_\_\_

**Outcomes Assessment:**

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

1. Pain Intensity

- The pain come and goes and is very mild
- The pain is very mild and does not vary much
- The pain is very Moderate and does not vary much
- The pain comes and goes and is moderate
- The pain is very severe and it is severe
- The pain is severe and does not vary much

2. Personal Care

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

3. Lifting

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

4. Reading

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

5. Headaches

- I have no headache at all
- I have slight headaches, which come infrequently
- I have moderate headaches, which come frequently
- I have severe headaches, which come frequently
- I have headaches almost all the time

6. Concentration

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

7. Work

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

8. Driving

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

9. Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed (less than 1 hr sleepless)
- My sleep is mildly disturbed (1-2 hrs sleepless)
- My sleep is moderately disturbed (2-3 hrs sleepless)
- My sleep is greatly disturbed (3-5 hrs sleepless)
- My sleep is completely disturbed (5-7 hrs sleepless)

10. Recreation

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



Name \_\_\_\_\_

Date \_\_\_\_\_

**Outcomes Assessment:**

**Back Pain Questionnaire- Check the Box of the answer**

1. Pain Intensity

- The pain come and goes and is very mild
- The pain is very mild and does not vary much
- The pain is very Moderate and does not vary much
- The pain comes and goes and is moderate
- The pain is very severe and it is severe
- The pain is severe and does not vary much

2. Personal Care

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it may cause some pain
- Washing and dressing increases the pain and I manage not to change my way of doing it
- Washing and dressing increases the pain and I find it necessary to change my way of doing it
- Because of the pain, I am unable to do some washing and dressing without help
- Because of the pain, I am unable to do any washing or dressing without help

3. Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me from lifting heavy objects off the floor
- Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned on a table
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very lightweights, at the most

4. Walking

- Pain does not prevent me from walking any distance
- Pain prevents me from walking more than 1 mile
- Pain prevents me from walking more than ½ mile
- Pain prevents me from walking more than ¼ mile
- I can only walk using a cane or crutch
- I am in bed most of the time and have to crawl to the toilet

5. Sitting

- I can sit in any chair as long as I like with out pain
- I can only sit in my favorite chair as long as I can
- Pain prevents me sitting more than 1 hour
- Pain prevents me sitting more than ½ hour
- Pain prevents me sitting more than 10 minutes
- Pain prevents me from sitting at all

6. Standing

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

7. Sleeping

- I get no pain in bed
- I get pain in bed, but It does not prevent me from sleeping well
- Because of pain, my normal nights sleep is reduced by less and 1 quarter
- Because of pain, my normal nights sleep is reduced by less than 1 half
- because of pain, my normal nights sleep is reduced by less than three quarters
- Pain prevents me from sleeping at all

8. Social Life

- My social life is normal and gives me no pain
- My social life is normal, but increases the degree of my pain
- Pain has significant effects on my social life apart from limiting my more energetic interest ex, dancing etc
- Pain has restricted my social life and I do not go out very often
- Pain has restricted my social life to my home
- I have hardly any social like because of the pain

9. Traveling

- I get no pain while traveling
- I get some pain while traveling, but none of my usual forms of travel make it any worse
- I get extra pain while traveling but it does not compel me to seek alternative forms of travel
- I get extra pain which compels me to seek alternative forms of travel
- Pain restricts all form of travel
- Pain prevents all forms of travel except those done lying down

10. Changing Degree of Pain

- My pain is rapidly getting better
- My pain fluctuates, but overall is definitely getting better
- My pain seems to be getting better, but improvements is slow at present
- My pain is neither getting better nor worse
- My pain is gradually worsening
- My pain is rapidly worsening



## **INFORMED CONSENT TO CHIROPRACTIC TREATMENT**

I hereby 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 incapacitated.)***

**Full Name of the Patient:** \_\_\_\_\_

**Full Name of Representative/Relation** \_\_\_\_\_

**Signature of Representative** \_\_\_\_\_

**Date:** \_\_\_\_\_



## ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

I hereby direct any and all insurance carriers, attorneys, agencies, governmental department, companies, individuals, and / or legal entities ("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 be 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** \_\_\_\_\_



## 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:

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**This consent was signed by:**

\_\_\_\_\_ Date: \_\_\_\_\_



## 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** \_\_\_\_\_