CAROLINA CHIROPRACTIC PLUS
OF RUTHERFORD COUNTY

Patient Data

Date:

Title:____ **First Name:**____________ **Middle Initial:**_______ **Last Name:**____________________

Preferred to be called :____

Address Line 1:____

Address Line 2:____

City:__________________________ **State:**____________ **Zip Code:**__________________

Home Phone: (______)_______-_______ **Work Phone** (______)________-_________

Cell Phone: (_______)________-_______

Date of Birth: _____/____/_____ **Age:**_______ **Sex:** ( )Male ( )Female

Email_________________________

Social Security Number:______-______-______ **Martial Status** ( )Single ( )Married ( )Other

Referred By:____

Employment Status: ( )Employed ( )Full-time Student ( )Part-time Student ( )Other (check one)
Employed By:____
Address:____
City:_______________________ **State:**_____ **Zip Code:**_______ **Phone:**__________________

Spouse Data

Is your spouse a patient in the clinic? ( ) Yes ( ) No
First Name:________________ **Middle Initial:**______ **Last Name:**__________________

Home Phone: (______)_______-_______ **Work Phone:** (_____)________-_________

Spouse's Date of Birth ______/______/______ **Spouse's SS#** _______-________-_______

Are they the policy holder? ( ) Yes ( ) No If yes, please complete below:

Employed By:____
Address:____
City: _____________________ **State:** _______ **Zip Code:**__________ **Phone:**________________

Emergency Contact

Contact Name: ____
Contact Phone: (________)_________-_________

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 + 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:

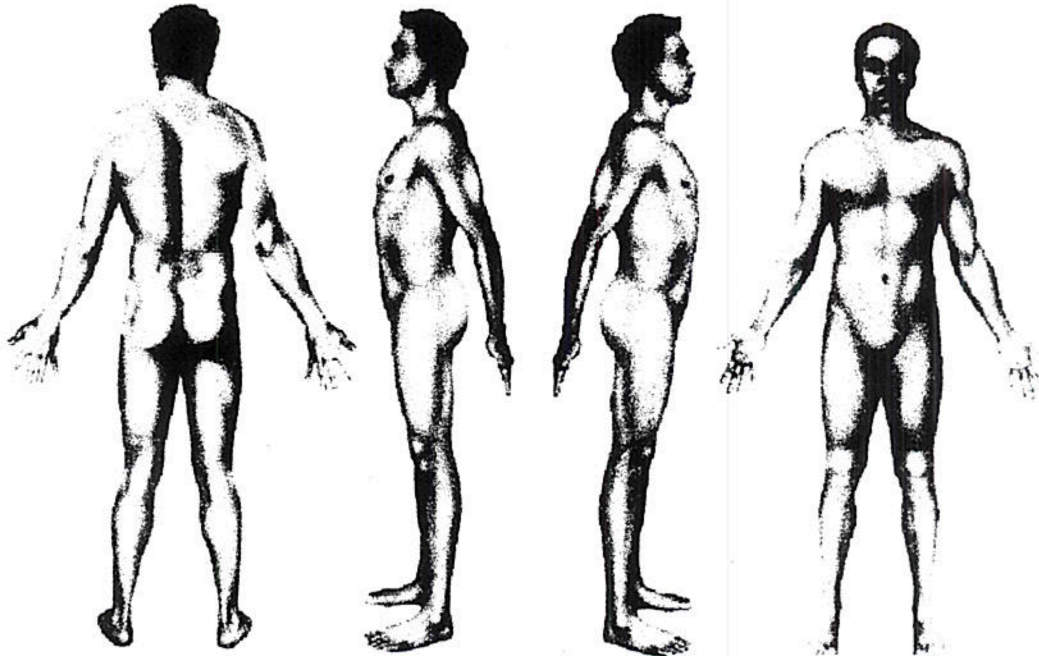
- ❑ Administration
- ❑ Construction
- ❑ Health care
- ❑ Household
- ❑ Business owner
- ❑ Daycare/childcare
- ❑ Heavy equipment operator
- ❑ Light manual labor
- ❑ Clerical/secretarial
- ❑ Executive/legal
- ❑ Heavy manual labor
- ❑ Manufacturing
- ❑ Computer user
- ❑ Food service industry
- ❑ Home services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

Recreational Activities:

- ❑ Backpacking
- ❑ Golf
- ❑ Soccer
- ❑ Weight Lifting
- ❑ Biking
- ❑ Racket Ball
- ❑ Swimming
- ❑ Boating
- ❑ Running
- ❑ Tennis
- ❑ Football
- ❑ Skiing
- ❑ Walking

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

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

Who is your primary care physician?______________________________
Name of 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 this chiropractic office 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 this chiropractic office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me to be credited 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's Signature____________________________ Date_______________
Guardian or Spouse's Signature authorizing care____________________________

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 neccessarry, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible______________________________) by the chiropratic physician and/or anyone working in this office authorizeed by the chiropractic physician.

I futher understand that such chiropractic services may be performed by the Physician of Chiropractic name here *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 an opportunity to discuss with *Dr. Sarah Merrison* and/or with other office or clinic personnel the nature and 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 risks 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 risks and complications. Futher, I wish to rely on the physician to exercise judgement during the course of the procedure which the physician feels are in my best interests 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 this facility.

To be completed by the patient:

____

Print Patient's Name

____

Signature of Patient

To be completed by the patient's represenative, if necessary (e.g.if the patient is a minor or is physically or mentaly in compacitated.)

____

Print Name of Patient

____

Print Name of Represenative

____

Signature of Represenative

ASSIGNMENT OF PROCEEDS, LIEN, AND AUTHORIZATION

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("condition") 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 Office relating to my condition ("charges"), with such payments to be made exclusively in the name of **CAROLINA CHIROPRACTIC PLUS** I further grant a lien to **CAROLINA CHIROPRACTIC PLUS** with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document (herein, "Assignment and Lien"), "benefits" shall include, but not be limited to proceeds from any settlement, judgement, or verdict, as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

In the event that I retain one or more attorneys to represent me in this matter who are not located in North Carolina, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Assignment and Lien. I further authorize and direct all payers to release to **CAROLINA CHIROPRACTIC PLUS** any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this Office to file a copy of this Assignment and Lien, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize **CAROLINA CHIROPRACTIC PLUS** to endorse/sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependants. I further authorize **CAROLINA CHIROPRACTIC PLUS** to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse or my dependents, regardless of these other charges are related to my condition.

I understand that I remain personally responsible for the total amount due **CAROLINA CHIROPRACTIC PLUS** for their services. This Assignment and Lien does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **CAROLINA CHIROPRACTIC PLUS** for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of **CAROLINA CHIROPRACTIC PLUS** and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the extent that the terms of those authorizations, whether executed at this office or any other office to the extent that the terms of those authorized conflict with the terms of this Assignment and Liens.

Patient Name (please print):____

Patient Signature:____ Date:__________

Name of Custodial Parent or Legal Guardian (please Print):______________________________

Parent/Guardian' Signature:______________________________________ Date:__________

HEALTH CARE AUTHORIZATION FORM

Patient's Name ____

Patients SS# ______________________________ Date of Birth ____________

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **CAROLINA CHIROPRACTIC PLUS** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- ❑ I give permission to **Carolina Chiropractic Plus** to use my address, phone number and clinical records to contact me with birthday cards, holiday related cards, newsletters and information about treatment alternatives or other health related information.

- ❑ I give **Carolina Chiropractic Plus** permission to use my name within the office for the purpose of our referral board, patient of the month announcement, testimonials, *Patients in the News Board*, *Pregnancy Board*, or in the case of a minor, our kids wall.

- ❑ By signing this form you are giving **Carolina Chiropractic Plus** permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **Carolina Chiropractic Plus**. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request and your signature.

ACKNOWLEDGMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges.

- The right to review the notice prior to singing the consent.
- The right to object to the use of my health information for the directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

______________________________ ______________________

Patient Signature Date

CAROLINA CHIROPRACTIC *Plus*

Dr. Sarah Merrison-McEntire

Courtesy Initial Visit Waiver

I understand and agree that all services rendered today are part of a complimentary/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 an opportunity to make an informed decision on whether or not to chose this treatment option, should mine be considered a chiropractic case.

In the event the doctor determines that chiropractic care 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 "courtesy initial 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 service," there is a fee required to release records/x-rays pertaining to this visit.

Patient Name: ____

Patient/Guardian Signature: ____

Date: _________________________

152 West Main Street • Forest City, NC 28043 • Ph: 828.245.0202 • Fax: 828.245.0422 • www.ncchiroplus.com

Name: ________________________ Date: ______________________

Outcome Assessment:

Oswestry Back Pain Questionnaire- check the box of the answer that most applies to you.

1. Pain Intensity
   - The Pain comes and goes and is very mild.
   - The pain is mild and does not vary much.
   - The pain is moderate and does not vary much.
   - The pain comes and goes and is moderate.
   - The pain comes and goes and 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 causes some pain.
   - Washing and dressing increases the pain, but 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 me extra pain.
   - Pain prevents me from lifting heavy weights off the floor.
   - Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table
   - Pain prevents me from lifting heavy weights, but I can mange 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 crutches
   - 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 without pain
   - I can only sit in my favorite chair as long as I like
   - Pain prevents me sitting more than 1 hour
   - Pain prevents me sitting more than ½ hour
   - Pain prevents 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 for longer than 1 hour without increasing pain.
   - I cannot stand for longer than ½ hour without increasing pain.
   - I cannot stand for longer than 10 minutes without increasing pain.
   - Pain prevents me from standing at all.

7. Sleeping
   - I get no pain bed
   - I get pain in bed, but I does not prevent me from sleeping well.
   - Because of pain, my normal night's sleep is reduced by less than one-quarter
   - Because of pain, my normal night's sleep is reduced by less than one-half
   - Because of pain, my normal night's 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 no significant effect on my social life apart from limiting my more energetic interests, eg., dancing, ect.
   - 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 life 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 I t does not compel me to seek alternative forms of travel.
   - I get extra pain while traveling which compels me to seek alternative forms of travel.
   - Pain restricts all forms 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 improvement is slow at present.
    - My pain is neither getting better nor worse
    - My pain is gradually worsening
    - My pain is rapidly worsening

Name: ______________________________ Date: ___________________________________

Outcomes Assessment:

Neck Pain Questionnaire- check the box of the answer that most applies to you.

1. Pain Intensity
   - I have no pain at the moment
   - The pain is very mild at the moment
   - The pain is moderate at the moment
   - The pain is fairly severe at the moment
   - The pain is very severe at the moment
   - The pain is the worst thing imaginable at the moment

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, e.g., 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 or carry 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 my neck.

5. Headaches
   - I have no headaches at all
   - I have slight headaches, which come infrequently
   - I have moderate 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 y usual work, but no more
   - I cannot do my usual work
   - 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 can drive as long as I want with moderate 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 engage in most, but not all of my usual recreation activities because of pain in my neck.
    - I can hardly do any recreation activities because of pain in my neck
    - I cannot do any recreation activities at all.