New Patient Demographics

Patient Data:

First Name:_______________ Middle Initial:_______ Last Name:_______________

Name you preferred to be called: _______________

Mailing Address: _______________

City: _______________State: _______________ Zip Code: _______________

Physical Address: (if different from mailing address) _______________ City: _______________ Zip Code: ______

Home Phone: (____)_______________ Work Phone: (_____)_______________ Ext: ____ Cell Phone: (____)_______________

Email Address: _______________ Date of birth: _____/_____/_____ Sex: ☐ Male ☐ Female

Social Security #: _______________ Marital Status: ☐ Single ☐ Married ☐ Other: ________

Employment Status: ☐ Employed ☐ Full time student ☐ Part time student ☐ Retired ☐ Other: ____

Insured's Data: IMPORTANT INFORMATION: PLEASE FILL OUT INSURANCE POLICY HOLDER'S INFORMATION BELOW

First Name: _______________ Middle Initial: ________ Last Name: _______________

Home Phone: (____)_______________ Work Phone: (_____)_______________ Ext: ____ Cell Phone: (____)_______________

Insured's Date of birth: _______/_______/_______ Insured's relationship to patient: _______________

Address Same as Patient: ☐ Yes ☐ No (if no then fill out their address below)

Address_______________

City: _______________State: _______________ Zip Code: _______________

Employer Data:

Place of Employment: _______________

Address_______________

City: _______________State: _______________ Zip Code: _______________

Spouse Data:

Is your spouse a patient in the clinic? ☐ Yes ☐ No

First Name: _______________ Middle Initial: ________ Last Name: _______________

Home Phone: (____)_______________ Work Phone: (_____)_______________ Ext: ____ Cell Phone: (____)_______________

Date of birth: _______/_______/______ Social Security #: _______________

Emergency Contact:

Contact Name: _______________ Phone Number: _______________

Relationship to you: _______________

Patient Name: ______________________ Date: ___________

Is it ok to call you at work? ☐ Yes ☐ No

How did you hear about our clinic?

☐ Attorney	☐ Physician	☐ Internet/Website	☐ Facebook	☐ Sign on building	☐ Direct Mail Ad
☐ Friend	☐ Family member	☐ Employer	☐ Yellow Pages	☐ Newspaper Ad	☐ Other

If you selected "family member", "friend", "physician", or other", please enter their name below:

____

Medical conditions:

☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart Disease

☐ Hypertension ☐ Psychiatric Illness ☐ Skin disorder ☐ Stroke

Surgeries:

☐ Appendectomy ☐ Cardiovascular procedure ☐ Cervical disc procedure ☐ Joint replacement

☐ Hysterectomy ☐ Laminectomies ☐ Transurethral prostate surgery

☐ Gallbladder ☐ Radical prostatectomy ☐ Other:________________ ☐ None

Allergies:

☐ Eggs ☐ Fish & Shellfish ☐ Milk or Lactose ☐ Peanuts ☐ Soy ☐ Wheat/Gluten ☐ ______

Social History:

Caffeine used	☐ not at all	☐ occasionally	☐ often
Drink alcohol	☐ not at all	☐ occasionally	☐ often
Chew tobacco	☐ not at all	☐ occasionally	☐ often
Experience stress	☐ not at all	☐ occasionally	☐ often
Exercise	☐ not at all	☐ occasionally	☐ often
Wear seatbelt	☐ not at all	☐ occasionally	☐ always

Family History: Please check all that apply N/A

Relation	Arthritis	Cancer	Cholesterol	Diabetes	Heart Problems	High Blood Pressure
Parent	☐	☐	☐	☐	☐	☐
Sibling	☐	☐	☐	☐	☐	☐

Substance Use: Please check all that apply N/A

None	**Alcohol**	**Amphetamines**	**Barbiturates**	**Cocaine**	**Crystal Meth**	**Heroine**	**Marijuana**
Past	☐	☐	☐	☐	☐	☐	☐
Present	☐	☐	☐	☐	☐	☐	☐

Occupational Activities:

☐ Administration	☐ Business owner	☐ Clerical/secretarial	☐ Computer User
☐ Construction	☐ Daycare/childcare	☐ Executive/legal	☐ Food service Industry
☐ Full time Student	☐ Healthcare	☐ Heavy equipment operator	☐ Homemaker
☐ Manufacturing	☐ Retired	☐ Tradesperson	☐ Other

CAROLINA
CHIROPRACTIC
PLUS

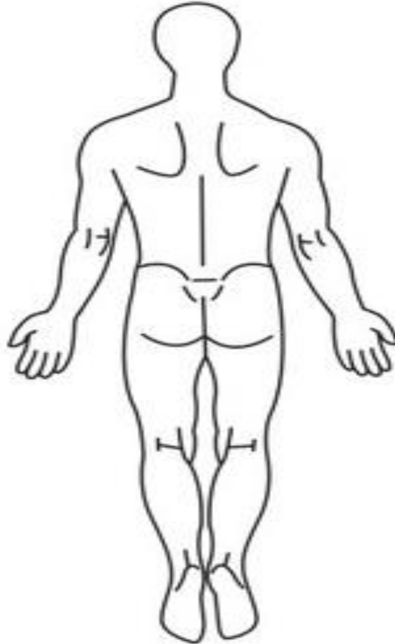
Patient Name: ______________________ Date: ___________

Pain Diagram

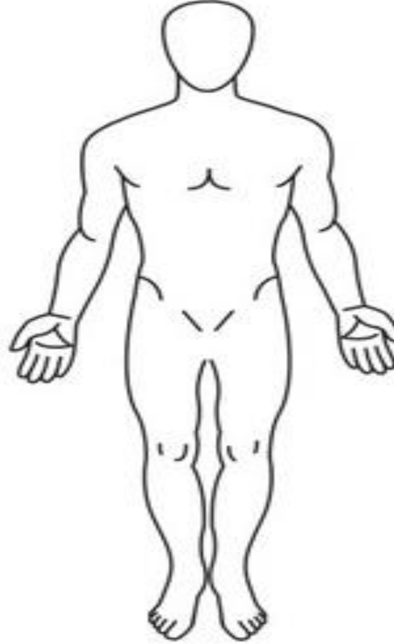
Tell us where you hurt. Mark the areas on the body where you feel pain.
Include all the affected areas. If your pain radiates, show an arrow from where it starts to where it stops.
Please extend the arrows as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache: >>>	Burning: XXX	Numbness: ===	Pins & Needles: 000	Stabbing: ///	Throbbing: ~~~

Right Side



Back



Front

Left Side

Describe your symptoms: ____

____

When did your symptoms start? Month________________Day____________________Year________________________

How did your symptoms begin? ____

____

How often do you experience your symptoms?

☐ Intermittently (0-25% of the day) ☐ Occasionally (26-50% of the day) ☐ Frequently (51-75% of the day) ☐ Constantly (70-100 % of the day)

What describes your symptoms?

☐ Burning ☐ Dull Ache ☐ Numb ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Tingling

How are your symptoms changing?

☐ Getting better ☐ Not changing ☐ Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (circle one)

0	1	2	3	4	5	6	7	8	9	10
(no pain)		(mild pain)			(moderate pain)				(worst pain imaginable)	

During the past 4 weeks, how much pain has interfered with your normal work? (including both inside and outside the home)

☐ Not at all ☐ A little bit ☐ Quite a bit ☐ Extremely ☐ Moderately

During the past 4 weeks, how much pain has interfered with your social life activities?

☐ Not at all ☐ A little bit ☐ Quite a bit ☐ Extremely ☐ Moderately

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 ☐ ___________

What treatment did you receive?

☐ Adjustments ☐ Physical Therapy ☐ Medication ☐ Surgery ☐ ___________

When did you receive this treatment?

☐ In the last month ☐ 2-3 months ago ☐ 3-6 months ago ☐ 6 months to a 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 ☐ ___________

When were these tests done?

☐ In the last month ☐ 2-3 months ago ☐ 3-6 months ago ☐ 6 months to a year ago

☐ 1-2 years ago ☐ 2-5 years ago ☐ 5-10 years ago ☐ ___________

Have you had similar symptoms in the past? ☐ Yes ☐ No

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

☐ This office ☐ Other chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ ___________

Who is your primary physician? ____

Name of Clinic: ______________________________ Clinic Phone Number: ______________________

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 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 to 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 to me will be immediately due and payable.

Release of Information

In the event that Dr. Brad Moffitt believes it is necessary for a second opinion or finds it necessary to contact my primary or treating physician, I authorize this office to release my medical records arising from said treatment.

___________ Patient or Guardian Initial

Assignment of Proceeds

I hereby direct all payers to release any information regarding any coverage or benefits to pay directly to Carolina Chiropractic Plus. I authorize this office to release any information to insurance carriers regarding my treatment to facilitate collection. I agree that all provisions to this agreement are reasonably necessary for the protection of the rights and interests of Carolina Chiropractic Plus and myself.

___________ Patient or Guardian Initial

Patients Signature: ______________________________ Date: ______________________

Guardian or Spouse's Signature authorizing care: ____