CAROLINA CHIROPRACTIC PLUS

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: _____

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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

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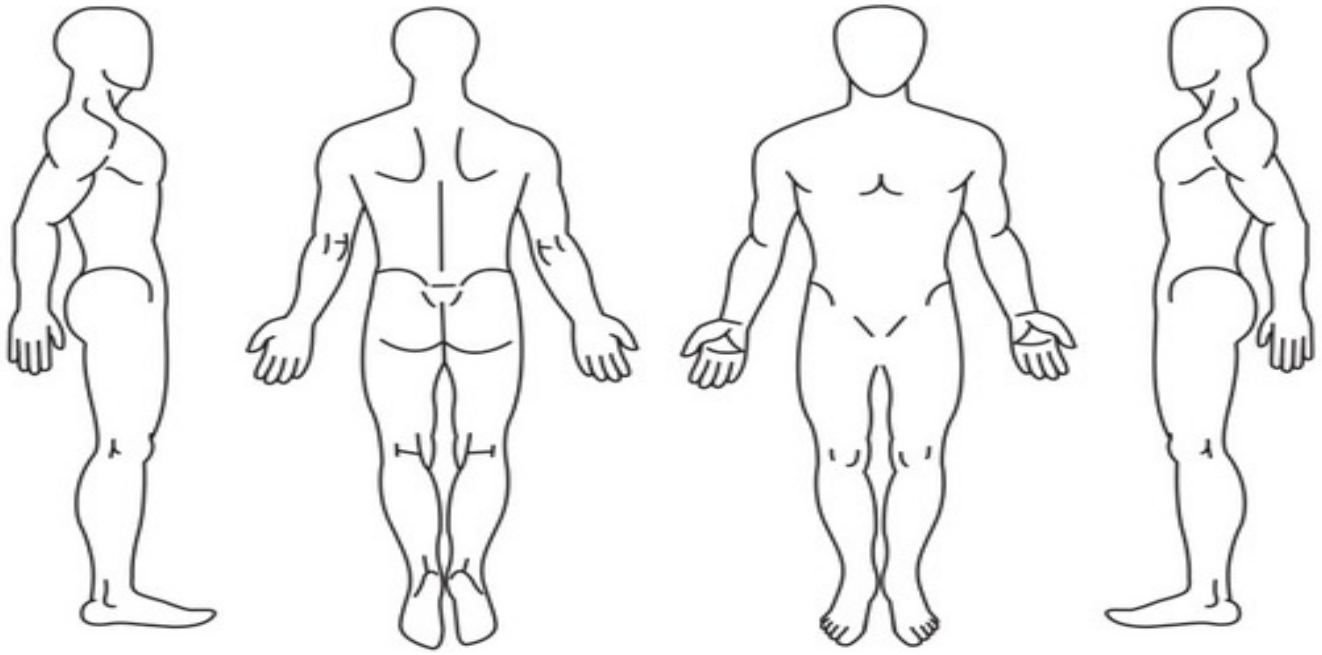
Patient Name: _____ Date: _____

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 the physicians of Carolina Chiropractic Plus 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 Parent/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 Parent/Guardian Initial**

Patients Signature: _____ **Date**: _____

Printed Patients Name: _____

Guardian or Spouse's Signature authorizing care: _____