WELCOME...

Patient Information

Carolina TotalCare
CHIROPRACTIC & WELLNESS

Name: ______________________________ I prefer to be called:______________

Mailing Address:____
Street City State Zip

Phone (mobile) ______________ (Hm) ______________ (e-mail) ______________

Birth Date:____/____/____ ☐ Male ☐ Female Can we leave a message? ☐ Yes ☐ No Email / Text you: ☐ Yes ☐ No

Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Minor # of Children:_____ Spouse or Parent / Guardian Name:______________

Employer:______________ Occupation:______________ Phone:______________

Emergency contact: Name:______________ Relation:______________ Best Ph#______________

Primary Physician's Name:______________ May we forward our findings to them? ☐ Yes ☐ No

Who (patient, doctor, etc.) referred you to our practice?______________ ☐ Insurance Book ☐ Internet

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No Date: ______________ If yes, what type? ☐ Auto ☐ Work ☐ Other______________

Has it been reported? ☐ Yes ☐ No If yes, to whom?______________

Insurance Information

Do you have Health Insurance? ☐ Yes ☐ No Name of Carrier: ______________

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: ______________

Policyholder's Name:______________ Policyholder's DOB: ____/____/____

Relationship to patient (if other than self):______________ Does your plan require a primary care Referral: ☐ Yes ☐ No

PLEASE PROVIDE THIS OFFICE WITH YOUR INSURANCE CARD(S)

We cannot file your insurance if this section is left incomplete or if your card isn't copied! Instead, your bill will be sent to you.

Assignment, Consent and Care Release

I certify that I (or my dependent) have insurance coverage with ______________ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.
______________(Initial here) to Allow Release of Information to Spouse

A patient coming to the doctor gives their permission and authority to care for the patient in accordance with appropriate tests, analysis diagnosis, and treatment. The clinical procedures performed are usually beneficial and seldom cause any problem. I do understand there may be some risks associated with any type of treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications. In rare cases, underlying physical defects, deformities, or pathologies, may render the patient more susceptible for injury. The doctor will not provide specific healthcare, if they are made aware of such problems by the patient, prior to treatment. Additionally, we offer treatments in an open room with other patients in the same room. Occasionally, comments about your symptoms, improvement or lack there of may be discussed at your treatment visits. The benefit of this setting is an increased learning environment about health.

PATIENT SIGNATURE (X)______________ DATE______________

SIGNATURE OF PARENT/GUARDIAN______________ DATE______________

HIPPA

I was given the opportunity to receive and review the office's Patient Notice of Information and privacy protection policy.

PATIENT SIGNATURE (X)______________ DATE______________

Reason for Your Visit / Current Symptom(s)

Chart #:_______________

NAME: ____________________________________

Symptoms you are here for: (by highest priority)

And/Or ☐ Wellness & Preventative Care

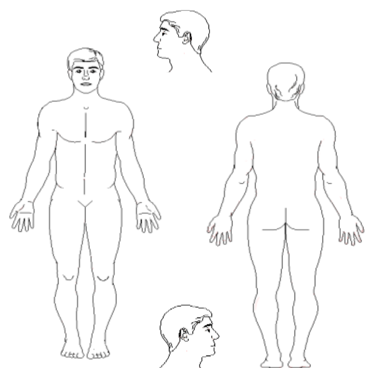
RATE THE PAIN OF ON A SCALE OF **0-10**
(0 = no pain, 10 = worst pain)

Complaint #1:____ _____ Currently / _____ It's Worst / _____ Best

Complaint #2:____ _____ Currently / _____ It's Worst / _____ Best

Compliant #3:____ _____ Currently / _____ It's Worst / _____ Best

LOCATION & QUALITY:
Circle the areas of your Pain (draw line where it travels to)



Is your Pain? ☐ Constant ☐ Come & Go -- What _______% of time?

Is it **getting worse**? ☐ No ☐ Yes ☐ Staying Same Worse at? ☐ Day ☐ Night

Does it: ☐ Stay in one spot? ☐ Travel (radiate) to other areas?

When did the symptoms start? ____________________________________

Do you know **what caused it**? ____________________________________

Have you **had it before**? ☐ No ☐ Yes When?__________________________

TYPE OF PAIN? ☐ Tight ☐ Stiff ☐ Ache ☐ Sharp ☐ Shooting ☐ Stabbing

☐ Throbbing ☐ Burning ☐ Dull ☐ Numb ☐ Tingling Other ___________

AGGRAVATING: What makes it worse?__________________________

RELIEVING: What makes it better?____________________________

TREATMENT TRIED: ☐ Prescription drugs ☐ Over counter drugs ☐ other Specialist (Who):____________________

☐ Massage Therapist ☐ Physical Therapist Other:_________________ **RELIEF:** ☐ Yes ☐ No ☐ Temporary

CHIROPRACTIC: Been treated before? ☐ No ☐ Yes How long ago?______ For what?__________________

GENERAL & SOCIAL HABITS:

What type of exercise you perform on a daily basis?___________________ Stretching? _____ / Days per Wk.

Describe your daily work habits? (ex: sit, stand, desk, heavy labor, etc.)________________________________

Consume: Caffeine? ____ cups/day Soft Drinks? ____ / day Alcohol? ______drinks per day / week

Smoke / use Tobacco? ☐ No ☐ Yes, How much per day?_______ If you quit, How long did you use? ___ yrs.

Drink Water: _____ 8 oz cups / day? Take Vitamins / Supplements daily: ☐ Yes ☐ No

What is the major stressor in your life?________________________ Your avg. Sleep per night? _______hrs

What is your preferred sleeping position?_______________ The age of your mattress/pillow?_____/_____yrs.

What's the most significant thing you could do to improve your health?______________________________

Anything else we should know?____

PATIENT/GUARDIAN SIGNATURE (X)__________________________________ DATE____________________