PATIENT INTAKE QUESTIONAIRE

CONFIDENTIAL PATIENT INFORMATION

Last Name _____ First Name _____ Date _____

SSN# _____ Age _____ DOB _____ Sex ☐ M ☐ F Height/Weight _____

*Parent/Guardian (if minor) _____ *Parent/Guardian Contact _____

Street Address _____ City, State, Zip _____

Email _____ Cell Phone _____ Other Phone _____

Marital Status _____ Occupation _____ ☐ Part-Time ☐ Full-Time

Emergency Contact _____ Relation _____ Emergency Phone _____

How did you hear about us? _____

Who is your primary care physician? _____

Have you ever seen a Chiropractor before? _____

Primary Insurance Company _____	Secondary Insurance Company _____
Insured's Name _____	Insured's Name _____
ID/Membership # _____	ID/Membership # _____
Policy/Group # _____	Policy/Group # _____
Customer Service Phone # _____	Customer Service Phone # _____

Are you seeing the doctor today due to a...

Work Related Injury? ☐ Yes ☐ No Date of accident? _____

Auto Accident? ☐ Yes ☐ No Date of accident? _____

RELEASE AND ASSIGNMENT

I agree to treatment by my doctor and such persons of the doctor's choosing, which may include interns, preceptors, chiropractic assistants, etc and hereby provide my consent for treatment.
Patient Signature _____ Date _____

I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to my chiropractor.
Patient Signature _____ Date _____

I understand that West Cary Wellness will prepare any necessary forms to assist me in submitting claims to my insurance provider and credit my accound when payment is received. However, I clearly understand that all services rendered to me are charged to me and I am responsible for payment unless other arrangements are made.
Patient Signature _____ Date _____

PATIENT HISTORY/EXAM FORM

CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office? _____

Of the above, which (if any) is your MAJOR complaint? _____

How long have you been experiencing your MAJOR complaint? _____

What was the CAUSE of your MAJOR complaint? _____

When did you first experience your MAJOR complaint? _____

Have you received care for this problem before? ☐ No ☐ Yes (please explain) _____

When do you notice your MAJOR complaint the most? ☐ Morning ☐ Night ☐ Both

How long does it last? _____ Minutes _____ Hours

What makes it feel WORSE? ☐ Sitting ☐ Standing ☐ Lying ☐ Activity Other _____

What makes it feel BETTER? ☐ Sitting ☐ Standing ☐ Lying ☐ Activity Other _____

Have you experienced this problem in the past? _____

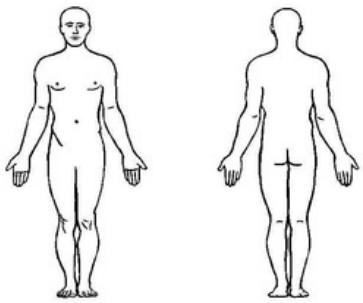
Which of the following best describes the character of your complaint? (Please circle all that apply)

Ache Burning Tingling Numb Sharp/Stabbing Cramping Dull/Deep

Does your pain radiate? ☐ No ☐ Yes (If so, where?) _____

On the diagram to the right, please indicate where you are experiencing your pain and mark the type of pain with the corresponding letters:

(A) Ache (B) Burning (T) Tingling (N) Numb
(S) Sharp/Stabbing (C) Cramping (D) Dull/Deep



On the scale below please circle your pain on a scale of 0 to 10
(0 being NO PAIN and 10 being the WORST pain you've experienced)

Pain at its WORST:	0	1	2	3	4	5	6	7	8	9	10
Pain at its BEST:	0	1	2	3	4	5	6	7	8	9	10

On the scale below please circle the percentage of time you experience your complaint

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Patient Signature _____ **Date** _____

YOUR TOP 3 HEALTH GOALS

1. _____
2. _____
3. _____

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries, or other injuries as an adult? ☐ No ☐ Yes

If yes, please explain: _____

Notable childhood injuries? ☐ No ☐ Yes(If yes, please explain) _____

Athletics injuries? ☐ No ☐ Yes (If yes, please explain) _____

Any auto accidents? ☐ No ☐ Yes (If yes, please explain) _____

Exercise frequency? ☐ None ☐ 1-2x per week ☐ 3-5x per week ☐ Daily

What position do you sleep in? ☐ Back ☐ Side ☐ Stomach

List any problems with flexibility (i.e. putting on shoes/socks, etc) _____

How many hours per day do you typically spend on average SITTING? _____

TOXINS: Chemical & Environmental Exposure

Please RATE your consumption for each of the following...

	None		Moderate			High		None		Moderate			High
Alcohol	0	1	2	3	4	5	Processed Foods	0	1	2	3	4	5
Water	0	1	2	3	4	5	Sugar/Sweeteners	0	1	2	3	4	5
Dairy	0	1	2	3	4	5	Caffeine/Coffee/etc	0	1	2	3	4	5
Grains/Gluten	0	1	2	3	4	5	Cigarettes	0	1	2	3	4	5

Please any Rx/OTC medications or nutritional supplements you're currently taking:

_____

THOUGHTS: Emotional Stresses & Challenges

Please RATE your stress level with regard to each of the following...

	None		Moderate			High		None		Moderate			High
Home	0	1	2	3	4	5	Money	0	1	2	3	4	5
Work	0	1	2	3	4	5	Health	0	1	2	3	4	5
Life	0	1	2	3	4	5	Family	0	1	2	3	4	5

Patient Signature _____ **Date** _____

GENERAL PATIENT HISTORY

Please mark (x) all current symptoms

HEAD

_____ Headache
- _____ Sinus
- _____ Entire Head
- _____ Back of Head
- _____ Forehead
- _____ Temples
- _____ Migraine

_____ Loss of Memory
_____ Light-Headed
_____ Loss of balance/dizzy
_____ Fainting
_____ Light bothers eyes
_____ Blurred vision
_____ Loss of vision
_____ Loss of taste
_____ Loss of hearing
_____ Pain in ears
_____ Ringing/Noises in ears

NECK

_____ Pain in neck
- _____ Sharp
- _____ Dull
- _____ Ache

_____ Pain with movement
- _____ Forward
- _____ Backward
- _____ Turning (L) (R)
- _____ Bending (L) (R)

_____"Pinched" nerve in neck
_____ Neck feels out of place
_____ Muscle spasms in neck
_____ Grinding sounds in neck
_____ Popping sounds in neck

SHOULDERS

_____ Pain in joint (L) (R)
_____ Pain across shoulders
_____ Arthritis (L) (R)
_____ Can't raise arm
- _____ Above shoulder level
- _____ Over head

_____ Tension in shoulders
_____ Pinched nerve in shoulder
_____ Muscle spasm in shoulder

ARMS AND HANDS

_____ Pain in arm
_____ Tennis/Golfers elbow
_____ Pain in hands/fingers (L) (R)
_____ Pins and needles sensation
_____ Numbness (L) (R)
_____ Hands cold
_____ Loss of grip strength
_____ Sore/swollen joints (fingers)

MIDBACK

_____ Mid-back pain
_____ Pain btw shoulder blades
_____ Sharp stabbing
_____ Dull ache
_____ Muscle spasms

CHEST

_____ Chest pain
_____ Shortness of breath
_____ Rib pain
_____ Breast pain
_____ Irregula heartbeat

ABDOMEN

_____ Nervous stomach
_____ Foods can't eat _____
_____ Nausea
_____ Gas
_____ Constipation
_____ Diarrhea
_____ Hemorrhoids

LOW BACK

_____ Lower back pain
- _____ Sharp
- _____ Dull
- _____ Ache

Location:
- _____ Upper lumbar
- _____ Lower lumbar
- _____ Hip(s)

_____ Low back pain worse when
- _____ Working
- _____ Lifting
- _____ Stooping
- _____ Standing
- _____ Sitting
- _____ Bending
- _____ Coughing
- _____ Lying down
- _____ Walking

Pain relieved when_____
_____ Sliipped disc
_____ Muscle spasms

HIPS, LEGS, FEET

_____ Pain in buttocks
_____ Pain in hip joint
_____ Pain down leg
_____ Knee pain
- _____ Outside
- _____ Inside

_____ Leg cramps
_____ Feet cramps
_____ Pins and needles in legs
_____ Numbness in legs/feet
_____ Swelling in legs/feet

***WOMEN ONLY**

_____ Menstrual pain
_____ Cramping
_____ Irregularity
_____ Cycle ___ days
_____ Birth control _____
_____ Hysterectomy
_____ Tumors/Cancer
_____ Discharge
_____ Menopause
_____ **Are you pregnant?**

***MEN ONLY**

_____ Urinary frequency
_____ Difficult urination
_____ Night urination
_____ Prostate swelling

General

_____ Nervousness
_____ Irritable
_____ Depressed
_____ Fatigue
_____ Run-down feeling
_____ Normal sleep = _____ Hrs
_____ Loss of sleep
_____ Weight loss
_____ Weight gain
_____ Diabetes
_____ Hypoglycemia
_____ Cigarettes _____ pack/day
_____ Coffee _____ cups/day

MEDICATIONS/OTHER

_____

_____

FAMILY HEALTH HISTORY

	Self	Father	Mother	Spouse	Brothers	Sisters	Children
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Disc Problems							
Drinker							
Drug Addiction							
Empyhsema							
Epilepsy							
Headaches							
Heart Trouble							
High Blood Pressure							
Kidney Trouble							
Migraine							
Nervousness							
Neuralgia							
Pinched Nerve							
Scoliosis							
Sinus Trouble							
Smoker							
Stomach Trouble							

POLICIES

1. All first visit charges are payable when wervices are rendered.

2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released unless the proper release documents are signed by patient and doctor. Copies can be made if necessary.

3. Method of payment you plan to use to take care of today's charges?

☐ Cash ☐ Check ☐ Credit Card

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that West Cary Wellness will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to West Cary Wellness will be credited to my accound upon receipt. However, I clearly understand and agree that all my services are charged directly to me and that I am responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect on this account. If an account balance remains unpaid for three months or longer, a monthly interest fee of 2% will apply to the account balance. I authorize West Cary Wellness to obtain a credit report if deemed necessary.

Patient Signature _____ Date _____

Guardian Signature Authorizing Care _____ Date _____

In case of emergency, please notify _____ Date _____

Relationship _____

Patient Address _____

PATIENT PRIVACY NOTICE

This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

In the course of your care at West Cary Wellness, we may use or disclose personal and health related information about you in the following ways:

Your personal health information, including your clinical records, may be disclosed to another health provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment. Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or an employer, if they are or may be responsible for the payment of your services. Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further you have the right to impact or obtain a compy of the information we will use for these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different format, please advise us in writing as to your preferences.

Under federal law, we are also permitted or required to use or disclose your information without your consent or authorization in these following circumstances:

-If we are providing health care services to you based on the order from another provider
-If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
-If there are substantial barries to communication with you, but in our professional judgement we believe you intend for us to provide care.
-If we are ordered by the appropriate agency.

Any use or disclosure of your protected health information other than outlined above will only be made with your written authorization.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to reques an amendment to your health information. Requests to inspect, copy, or amend your health information must be provided to us in writing.

We are required by state and federal law to maintain the privacy of your file and the protected health information therein. We are also required to provide you with this notice of our privacy practices.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to altar or amend the terms of this notice. If changes are made to our privacy policy we will notify you in writing. Any change in our privacy notice will apply to all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by federal privacy rules.

If you have a complaint regarding our privacy policy or privacy practices, you should direct your complaint to the Privacy Officer (or business owner) at 351 Wellesley Trade Ln, Suite 101, Cary NC, 27519.

This office utilizes an "open treatment" environment for ongoing patient care. "Open Treatment" involves the possibility of our patients being see in the same treatment environment at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within hearing of other patients and staff. A private, closed and confidential setting is provided for history taking, examinations, report of findings, etc. as determined by the doctor or staff. The use of this format is to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and information. If you choose not to be adjusted or use traction in an 'open treatment' environment, other arrangements will be made for you. This office also requests the presence of your spouse or significant other at your Doctor's Report appointment for the purpose of health education.

This notice is effective as of January 20, 2013. This notice and any alterations made hereto will expire seven years after this date. My signature acknowledges that I have received a copy of this notice.

Signature _____ Printed Name _____ Date _____

HISTORY, EXAM, & X-RAY FINDINGS

Patient History

Exam Findings

X-Ray Findings