West Cary Wellness
351 Wellesley Trade Lane, Suite 101
Cary NC 27519

Alex Brennan, DC
www.westcarywellness.com
(919) 303-1577

PATIENT INFORMATION- Please Print

GENERAL INFORMATION

Patient Last Name_____ First Name_____
Address_____ Care of_____
(Parent or financially responsible person)
City_____ State_____ Zip Code_____ Phone (Home)_____
No. Children _____ Phone (Work)_____
Email Address_____ Cell Phone_____

Sex M F	Married Single Widowed Divorced	Age	Date of Birth / /	Referred by:

Employer's Name _____
Address_____
City_____ State_____ Zip Code_____
Phone_____ Occupation_____

EMPLOYED Full Time Part Time Not Employed Retired
STUDENT Full Time Part Time Non-Student

Spouse's Name_____ Spouse's Employer_____
Spouse's Date of Birth_____

INSURANCE INFORMATION

Primary Insurance Company Name	Secondary Insurance Company Name
_____	_____
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:
(If yes, please inform the front desk)
Work Related Injury? Yes_____ No_____ Date of Injury_____

Auto Accident? Yes_____ No_____ Date of Injury_____

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's 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's 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 account 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's Signature_____ Date_____

West Cary Wellness
351 Wellesley Trade Lane, Suite 101
Cary NC 27519

Alex Brennan, DC
www.westcarywellness.com
(919) 303-1577

PATIENT HISTORY/EXAMINATION FORM

Complete ALL Questions below

1. What are your **major** complaint(s)/ illnesses?_____
_____

2. What are your **minor** complaint(s)/illnesses?_____
_____

3. How **long** have you been experiencing your major complaint?
□ Days □ Weeks □ Months □ Years

Mechanism of Injury

4. What was the **cause** of your major complaint (how did it happen)?_____
_____
_____

5. **When** did you first experience your major complaint?_____

6. What have you done **prior** to coming to this office to treat your major and minor complaints?_____
_____
_____

7. When do you **notice** your complaint(s) the most? □ AM □ PM □ BOTH

8. How long does it last? _____ Minutes _____ Hours

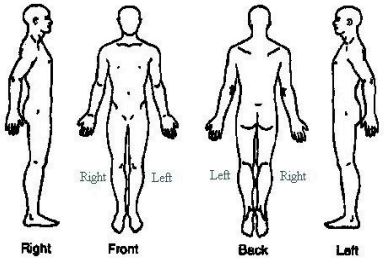
9. What makes it feel **worse**? □ Sitting □ Standing □ Lying □ Activity Other_____

10. What makes it feel **better**? □ Sitting □ Standing □ Lying □ Activity □ Drugs Other_____

11. What best describes the character and quality of your major illness or pain?
A. ache B. burning pain T: tingling N: numbness S. sharp C: cramping D. dull pain

12. Have you had this problem in the past?

13. On the diagram below, please **show** where you are experiencing all of your present complaints using the following letters:
A. ache B. burning pain T: tingling N: numbness S. sharp C: cramping D. dull pain



14. On the scale below, please **circle** the severity and intensity of your main complaint (at its' worst):

None		Slight		Mild		Moderate			Severe
1	2	3	4	5	6	7	8	9	10

15. On the scale below, please **circle** the percentage of time you experience of your major complaint:

Occasional		Intermittent				Frequent			Constant
1	2	3	4	5	6	7	8	9	10

16. Does your pain radiate? Yes____No_____If yes, where does it radiate to? _____

Signature_____ **Date**_____

West Cary Wellness
351 Wellesley Trade Lane, Suite 101
Cary NC 27519

Alex Brennan, DC
www.westcarywellness.com
(919) 303-1577

Patient History
Please check (x) all present symptoms

HEAD:

_____Headache
- _____Sinus
- _____Entire Head
- _____Back of Head
- _____Forehead
- _____Temples
- _____Migraine

_____Loss of Memory
_____ Light-headed
_____ Fainting
_____Light bothers eyes
_____Blurred vision
_____Double vision
_____Loss of vision
_____Loss of balance
_____Loss of taste
_____Loss of hearing
_____Dizziness
_____Pain in ears
_____Ringing or noises in ears

NECK:

_____Pain in neck
- ____Sharp
- ____Dull
- ____Ache

_____Neck 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 spasms in shoulder

ARMS AND HANDS:

_____Pain in arm
_____ Tennis elbow
_____Pain in hands/fingers (L) (R)
_____Pins and needles sensation
_____Numbness (L) (R)
_____Hands cold
_____Loss of grip strength
_____Sore/swollen joints in fingers

MIDBACK:

_____Mid-back pain
_____Pain between shoulder blades
_____Sharp stabbing
_____Dull ache
_____Muscle Spasms

CHEST:

_____Chest pain
_____Shortness of breath
_____Rib pain
_____Breast pain
_____Irregular heartbeat

ABDOMEN:

_____Nervous stomach
_____Foods cant eat_____
_____Nausea
_____Gas
_____Constipation
_____Diarrhea
_____Hemorrhoids

LOW BACK:

_____Lower back pain
- _____Sharp
- _____Dull
- _____Ache

Location:
- _____Upper lumbar
- _____Lower lumbar
- _____Hip

_____Low back pain is worse when
- _____Working
- _____Lifting
- _____Stooping
- _____Standing
- _____Sitting
- _____Bending
- _____Coughing
- _____Lying Down
- _____Walking

Pain relieved when_____
_____Slipped Disc
_____Low back feels out of place
_____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
_____type
_____Hysterectomy
_____Tumors/Cancer
_____Discharge
_____Menopause
_____Abortions
_____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
_____Loss of weight
_____Weight Gain
_____Diabetes
_____Hypoglycemia
_____Cigarettes _____pack/day
_____Coffee _____cups/day

OTHER_____

Medications_____
_____

West Cary Wellness
351 Wellesley Trade Lane, Suite 101
Cary NC 27519

Alex Brennan, DC
www.westcarywellness.com
(919) 303-1577

POLICIES

1. All first visit charges are payable when services 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. Copies can be made if necessary.

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

□ Cash □ Check □Visa/Mastercard

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 Center 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 account 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_____

Relationship_____

Address_____

_____

_____

Phone #_____

West Cary Wellness
351 Wellesley Trade Lane, Suite 101
Cary NC 27519

Alex Brennan, DC
www.westcarywellness.com
(919) 303-1577

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 copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you of 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 form 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 barriers to communication with you, but in our professional judgment 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 outlines 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 request 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 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, our privacy practices you should direct your complaint to the Privacy Officer at 351 Wellesley Trade Lane, 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 seen 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_____

West Cary Wellness
351 Wellesley Trade Lane, Suite 101
Cary NC 27519

Alex Brennan, DC
www.westcarywellness.com
(919) 303-1577

HEALTH HISTORY OF FAMILY MEMBERS

The reason for this form is to assist the doctor by providing past health history information for their review

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