CONFIDENTIAL PATIENT INFORMATION

Name_____ Date _____ SSN_____
Home Ph._____ Cell Ph._____
Address _____City _____State _____ Zip _____ Sex M F
Age _____ Birth Date_____ Marital Status M S W D How many children? _____
Occupation_____ Employer_____ Office Ph. _____
Work Address_____ Email Address_____
Name of Spouse _____ Occupation _____ Employer_____
Who may we thank for referring you? _____
Have you had chiropractic care? Yes No If so, who was the doctor and when?_____
Would you like to receive Email Reminders Text Reminders, Cellular Carrier: _____
Please list your most recent traumas (auto accidents, major falls, sport injuries, etc.):

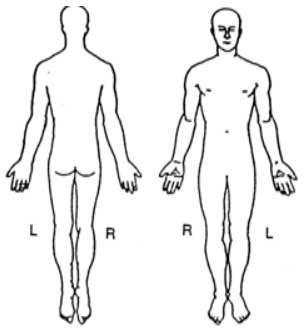
1. 1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

PRIMARY CONDITION – PLEASE DESCRIBE ONE AREA OF COMPLAINT

Please describe your primary complaint: _____
When did it start? _____ Have you had it in the past: Y N When: _____
Please check the appropriate box: The pain is constant it comes and goes
On a scale from 1-10 with 10 being the worst circle the level of pain: 1 2 3 4 5 6 7 8 9 10
Please check the box(es) that best describes the pain: Sharp/Stabbing Pain Burning Dull Pain Tingling Numbness Weakness Restriction Other _____
Does your pain travel from the point of pain? Y N If yes, where: _____
What makes it better? Chiropractic Ice Heat Massage Medication Resting Sitting Standing Walking Lying Down Other _____
What makes it worse? Bowel Movements Breathing Coughing Driving Sitting Lying Down Sneezing Walking Working Other _____
Have you missed any school/work due to this complaint? Y N
Is this the result of an automobile accident: Y N Work related injury: Y N
If yes, to either question above, please explain: _____

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull



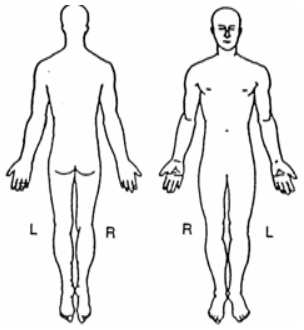
Have you received any other treatment for this condition: Y N If yes, indicate treatment Chiropractic Physical Therapy Surgery Other _____ Doctor's Name who provided Treatment: _____
*DOCTOR USE ONLY: _____

SECONDARY CONDITION – (if applicable)

Please describe your secondary complaint: _____
When did it start? _____ Have you had it in the past: Y N When: _____
Please check the appropriate box: The pain is constant it comes and goes
On a scale from 1-10 with 10 being the worst circle the level of pain: 1 2 3 4 5 6 7 8 9 10
Please check the box(es) that best describes the pain: Sharp/Stabbing Pain Burning Dull Pain Tingling Numbness Weakness Restriction Other _____
Does your pain travel from the point of pain? Y N If yes, where: _____
What makes it better? Chiropractic Ice Heat Massage Medication Resting Sitting Standing Walking Lying Down Other _____
What makes it worse? Bowel Movements Breathing Coughing Driving Sitting Lying Down Sneezing Walking Working Other _____
Have you missed any school/work due to this complaint? Y N
Is this the result of an automobile accident: Y N Work related injury: Y N
If yes, to either question above, please explain: _____

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull



Have you received any other treatment for this condition: Y N If yes, indicate treatment Chiropractic Physical Therapy Surgery Other _____ Doctor's Name who provided Treatment: _____

*DOCTOR USE ONLY: _____

_____

ADDITIONAL CONDITION – (if applicable)

Please describe your additional complaint: _____

When did it start? _____ Have you had it in the past: Y N When: _____

Please check the appropriate box: The pain is constant it comes and goes

On a scale from 1-10 with 10 being the worst circle the level of pain: 1 2 3 4 5 6 7 8 9 10

Please check the box(es) that best describes the pain: Sharp/Stabbing Pain Burning Dull Pain Tingling Numbness Weakness Restriction Other _____

Does your pain travel from the point of pain? Y N If yes, where: _____

What makes it better? Chiropractic Ice Heat Massage Medication Resting Sitting Standing Walking Lying Down Other _____

What makes it worse? Bowel Movements Breathing Coughing Driving Sitting Lying Down Sneezing Walking Working Other _____

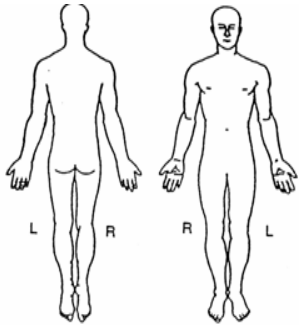
Have you missed any school/work due to this complaint? Y N

Is this the result of an automobile accident: Y N Work related injury: Y N

If yes, to either question above, please explain: _____

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull



Have you received any other treatment for this condition: Y N If yes, indicate treatment Chiropractic Physical Therapy Surgery Other _____ Doctor's Name who provided Treatment: _____

*DOCTOR USE ONLY: _____

_____

Activities of Daily Living: Please circle the activities that are affected by your current complaint.

Bathing	Cooking	Laying down	Sleeping
Bending	Daily pet care	Lifting items	Sneezing
Brushing teeth	Dressing	Reading	Sports
Caring for family	Swallowing	Reaching	Static sitting
Carrying items	Driving	Running	Static standing
Changing of pos.	Eating	Shaving	Washing body/hair
Climbing stairs	Exercising	Showering	Work activities
Computer use	Getting out of bed	Sexual activities	Yard work
Concentration	Household chores		

Medication: Please list all medications you are currently taking. We offer information as to what nutrient deficiencies will be caused by the medications you are taking. If you desire this information please inform your doctor.

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

Nutrients: Please list all nutrients you are currently taking. We offer to evaluate the formulations of your supplementation. If you desire this evaluation please bring your nutrients on your next visit.

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

Females Only: Are you currently having menstrual cycles? Y N If yes, when was the first day of your last cycle? _____ Is there any chance you are pregnant? Y N If yes, how many weeks? _____

Please sign to verify the above information is correct to the best of your knowledge. _____

Family History: Insert age and check any box that applies

	Age (if living)	Heart Dx	High Cholest	High Bl Pressure	Diabetes	Cancer	Anemia	Neck Pain	Low Bck Pain	Carpal Tunnel	Head aches	Obesity
Self												
Mom												
Dad												
Brother												
Sister												
Other ____												

Doctor's Use Only: _____
_____

LIFESTYLE: Your lifestyle, diet and exercise habits play an extremely important role in your overall health and risk of chronic disease. The following questions are designed to help us understand your habits, desires as well as commitments to make changes to those habits if necessary.

Diet:

1. How much do you drink? _____8-oz. glass water/day _____caffeinated drinks/day _____alcoholic drinks/week
2. How many times do you eat fast food each week? _____
3. Y N Do you smoke? If yes, how many packs a day? _____
4. Y N Do you have any food allergies? If yes, please name:_____
5. How many servings of fruits & vegetables are you eating a day? 0 1 2 3 4 5 6 7 8 9 10
   1 medium fruit = 1 serving 1 cup raw vegetables = 1 serving

Body Composition and Exercise:

1. Y N Are you at your ideal weight? Current Weight _____ If no, what is your desired weight? _____
2. Y N Are you interested in weight management?
3. Y N Do you engage in any cardiovascular exercise (e.g. aerobics, walking, swimming, etc.)?
   If yes, which activities?_____ _____Days Per Wk____ Duration _____
4. Y N Do you do any form of resistance exercises (lift weights) on a consistent basis? Days per week _____
5. Y N Do you ever experience pain after exercising? If yes, where? _____Type of Pain_____

Commitment and Goals:

1. On a scale of 1 to 10, what level of stress do you experience daily? 1 2 3 4 5 6 7 8 9 10
2. On a scale of 1 to 10, what is your commitment to making a lifestyle improvement? 1 2 3 4 5 6 7 8 9 10
3. What are your health goals for the next 6 months?_____
_____

Primary Care Physician

Primary Care Physician: _____ Physician Phone #: _____

Address: _____ City:_____ State:_____

Check here if you do NOT authorize this office to communicate with my primary physician about the care I receive.

I verify that the information I have provided in this document is true and I give the doctor consent to treat me.

Name: _____ Signature: _____ Date: _____

Subjective Health Assessment

Please rate the following symptoms that you have experienced during the past 30 days

0 = Never 1 = Occasional and Mild 2 = Occasional and Severe 3 = Often and Mild 4 = Often and Severe

Head

0	1	2	3	4	Headache				
0	1	2	3	4	Faintness				
0	1	2	3	4	Dizziness				
0	1	2	3	4	Sleeplessness	___Total			

Eyes, Ears, Nose, Throat

0	1	2	3	4	Stuffy Nose	
0	1	2	3	4	Sinus Trouble	
0	1	2	3	4	Hay Fever	
0	1	2	3	4	Sneezing	
0	1	2	3	4	Nasal Congestion	
0	1	2	3	4	Swollen Eyes	
0	1	2	3	4	Reddened Eyes	
0	1	2	3	4	Watery, Itchy Eyes	
0	1	2	3	4	Dark Circles Under Eyes	
0	1	2	3	4	Earache, Ear Infection	
0	1	2	3	4	Ringing in the Ears	
0	1	2	3	4	Coughing	
0	1	2	3	4	Sore Throat	
0	1	2	3	4	Hoarseness, Loss of Voice	
0	1	2	3	4	Canker Sore	___Total

Memory, Emotions

0	1	2	3	4	Mood Swings	
0	1	2	3	4	Anxiety, Nervousness	
0	1	2	3	4	Anger, Irritability	
0	1	2	3	4	Aggressiveness	
0	1	2	3	4	Depression	
0	1	2	3	4	Poor Memory	
0	1	2	3	4	Confusion	
0	1	2	3	4	Lack of Concentration	
0	1	2	3	4	Difficulty in Making Decisions	___Total

Sleep

0	1	2	3	4	Trouble Getting Asleep	
0	1	2	3	4	Trouble Staying Asleep	
0	1	2	3	4	Snoring	
0	1	2	3	4	Wake up tired	
0	1	2	3	4	Fall asleep during the day	___Total

Heart, Lungs

0	1	2	3	4	Irregular Heart Beat	
0	1	2	3	4	Rapid, Pounding Heart Beat	
0	1	2	3	4	Chest Pain	
0	1	2	3	4	Chest Congestion	
0	1	2	3	4	Asthma	
0	1	2	3	4	Bronchitis	___Total

Skin

0	1	2	3	4	Acne	
0	1	2	3	4	Dry, Scaly Skin	
0	1	2	3	4	Hair Loss	
0	1	2	3	4	Hot Flashes	___Total

Digestion

0	1	2	3	4	Nausea, Vomiting	
0	1	2	3	4	Diarrhea	
0	1	2	3	4	Constipation	
0	1	2	3	4	Heartburn	
0	1	2	3	4	Stomach Pain	
0	1	2	3	4	Bloating	
0	1	2	3	4	Belching, Gas	___Total

Joints

0	1	2	3	4	Stiffness/Lack of Motion	
0	1	2	3	4	Arthritis	
0	1	2	3	4	Pain in the Joints	
0	1	2	3	4	Pain in the Muscles	___Total

Energy Levels

0	1	2	3	4	Weakness	
0	1	2	3	4	Fatigue	
0	1	2	3	4	Hyperactivity	
0	1	2	3	4	Restlessness	___Total

Weight

0	1	2	3	4	Binge Eating/Drinking	
0	1	2	3	4	Craving Certain Foods	
0	1	2	3	4	Excessive Weight	
0	1	2	3	4	Water Retention	
0	1	2	3	4	Overweight	___Total

Grand Total _____

PATIENT CONSENT FORM

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I, _____ hereby state that by signing this consent, I acknowledge and agree as follows:

___ 1. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide analysis and treatment for me, and also necessary for the practice to obtain payment for that treatment and to carry out its healthcare operations. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has encouraged me to read the privacy notice carefully prior to signing this consent.

____ 2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.

____ 3. I understand that, and consent to, the following appointment reminders that will be used by the practice:

Postcards mailed to the addresses I have provided.

Calling or texting me at the numbers I have provided and leaving messages for me on my voicemail or with the individual answering the phone.

____ 4. The practice may use and/or disclose my PHI (which includes information about my health or condition, analysis, and the treatment provided to me) in order for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

____ 5. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.

____ 6. I understand that this consent is valid as long as I am a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, the practices has the right to refuse to treat me.

____ 7. I give Greenville Spine Institute permission to treat me in a room that is not fully enclosed. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, I understand the doctor will provide a private room for consultations

____ 8. The doctor recommends that my spouse be present at my report of findings visit; therefore I hereby give permission for my protected health information to be disclosed at that time and at any time my spouse contacts the office to check on my status.

____ 9. Greenville Spine Institute is a residential training facility. I understand that my examinations and/or treatments may be observed by resident and intern chiropractors; should I need to discuss my PHI privately, a private consultation room will be provided.

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat me.

Date:_____

Patient's Name (Printed) _____

Patient Name (Signed)_____

Patient DOB:_____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective.

The primary goal of our office is to help you return to the daily activities that you desire to be able to complete. During your initial consultation, we will determine specific goals to work towards achieving. Our treatment recommendations will be based upon our findings during examination(s) and your goals. These recommendations may include chiropractic adjustments, passive rehabilitative therapies, active rehabilitative exercises, and/or specific home care activities.

To obtain the best results possible, we take a team approach a Greenville Spine Institute. This means that our doctor(s), staff members, and patients work together; each doing their part, to ensure the best results possible.

If during the course of our consultation(s) or examination(s), we encounter non-chiropractic or unusual findings, we will advise you and refer you for management by the appropriate medical professional.

Additional information is provided on our website at www.GreenvilleSpine.com.

I have read and understand the information above.

Print Name:_____ Sign:_____ Date:_____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

To: Greenville Spine Institute

1. You are authorized to release any information you deem appropriate concerning my health condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges occurred at this office.
2. I authorize and assign the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services of otherwise obligated to make payment to me or you based in whole or in part upon the charges for your services.
3. I give assignment lien against any claims against a third party whose negligence may have caused my injury, up to the bill for treatment.
4. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name (s) of which I believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to comprise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you.

Print Name:_____ Sign:_____ Date:_____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Name: _____ Today's Date: ___/___/___

ACCIDENT DETAILS:

Date of Accident: ___/___/___ Time of Day: _____ AM PM Location of Accident: _____

City or town in which accident took place: _____ State: _____

Were you a ☐ Driver ☐ Passenger ☐ Pedestrian Name of Driver (if not you): _____

Were you struck from ☐ Behind ☐ Right Side ☐ Left Side ☐ Front

Were you looking straight ahead, to the left, or to the right? ☐ Straight Ahead ☐ To the Left ☐ To the Right

Was your vehicle ☐ stopped to make a turn ☐ stopped for a traffic signal ☐ parked ☐ moving at the time of impact

Other: _____

Did your body strike anything in the car? ☐ YES ☐ NO Describe in detail: _____

_____

If so were you aware of the impact? ☐ YES ☐ NO What part of the body endured the impact? _____

Were you wearing a seat belt? ☐ YES ☐ NO Did you have to readjust the seat after the collision? ☐ YES ☐ NO

Did air bag deploy? ☐ YES ☐ NO

Was weather conditions wet or dry? _____

Describe in detail how the accident occurred: _____

_____

_____

What was the height of the headrest? _____ Were you rendered unconscious as a result of the collision? ☐ YES ☐ NO

Were you taken to the hospital after the accident? ☐ YES ☐ NO By ambulance or private car? _____

Were you taken to the hospital *immediately* after the accident? ☐ YES ☐ NO

If not, how much time had elapsed before you went to the hospital? _____

Which hospital were you taken to? _____

Have you been x-rayed since the accident? ☐ YES ☐ NO If so, where? _____

Have you received an MRI since the accident? ☐ YES ☐ NO If so, where? _____

Have you lost any days of work as a result of the accident? ☐ YES ☐ NO If yes, how many days have you lost? _____

Have you ever been in a previous auto accident? Describe all instances, giving approximate dates of the accidents, as well as the injuries sustained, and names of attorneys who represented you.

Date of Accident: ____/____/____ Injuries sustained: _____

Name of Attorney in That Case: _____ Were you a Medicare Patient at the Time? ☐ YES ☐ NO

Approximate Year / Date When Case Settled or Was Resolved: _____

Date of Accident: ____/____/____ Injuries sustained: _____

Name of Attorney in That Case: _____ Were you a Medicare Patient at the Time? ☐ YES ☐ NO

Approximate Year / Date When Case Settled or Was Resolved: _____

OTHER AUTO INFORMATION:

Did a police officer write up a police report on the accident? ☐ YES ☐ NO

Do you have a copy of the police report? ☐ YES ☐ NO *(if yes, please provide our office with a copy of this report)*

Was a ticket or citation issued by a police officer as a result of the accident? ☐ YES ☐ NO

Who received the ticket or citation? _____

Do you have any information, including insurance information, concerning the other parties involved in the accident? ☐ YES ☐ NO

(If yes, please provide our office with a copy of this information)

Did the accident involve a *hit-and-run* driver? ☐ YES ☐ NO

Are you, yourself, licensed to drive? ☐ YES ☐ NO *(please provide our office with a copy of your license)*

Was the car in which you were at the time of the accident registered? ☐ YES ☐ NO *(please provide a copy of the registration)*

Other: _____

Were you in your own vehicle or someone else's at the time of the accident? Check one.

☐ My own vehicle ☐ my spouse's ☐ my parent's ☐ a friend's ☐ other

If you were in someone else's vehicle, answer the following:

Name of Owner: _____

Address of Owner: _____

Do you reside with a family member who owns their own vehicle or is insured under some other auto policy? – Automobile insurance laws in applicable states require this info (check all that apply)

☐ Spouse ☐ Father ☐ Mother ☐ Guardian / Foster Parent ☐ Grandparent ☐ Sister / Brother ☐ Child ☐ None

Your Auto Insurance Company (at the time of accident): _____ Phone or City: _____

Agent: _____ Phone or City: _____

Was there any property damage to either of the vehicles as a result of the accident?

☐ both vehicles ☐ the other person's vehicle ☐ the vehicle I was in ☐ Neither vehicle was damaged

Have you been contacted by an adjuster from the other party's insurance company regarding this claim? ☐ YES ☐ NO

Adjuster: _____ Company: _____ Phone: _____

Check all that apply: ☐ I have settled my personal injury claim with this company ☐ I have settled the property damage claim

☐ I have signed an agreement which will pay my medical expenses for a period of time (explain):

_____

☐ I have not signed any agreement, nor settled any portion of my claim.

Are you currently represented by an attorney? ☐ YES ☐ NO If NO, do you wish to retain an attorney ☐ YES ☐ NO

Name of Attorney: _____ Phone or City: _____