

NEW PATIENT INFORMATION

Welcome! Please allow our staff to photocopy your driver's license and Medicare card (if applicable.)

PLEASE PRINT CLEARLY.

Full Name: _____ E-mail: _____ Gender: M F
Age: _____ Birth Date: _____ Address: _____
City: _____ State: _____ Zip: _____ Social Security#: _____ - _____ - _____ Driver's
License #: _____ Home Phone: (____) _____
Cell Phone: (____) _____ Work Phone: (____) _____
Marital Status: S Marr. Div Wid. # of Children: _____ Work Status: ☐ Full time ☐ Part-time ☐ Retired
Females: Last Menstruation _____ Pregnant? Y N Nursing? Y N
Employer: _____ Occupation: _____
Employer Address: _____ City: _____ State: _____ Zip: _____
Name of Spouse, Parent or Guardian: _____ Age: _____ Birth Date: _____
Spouse's Employer: _____ Spouse's Occupation: _____
Work Phone: (____) _____
In case of an Emergency Contact: _____ Relationship: _____
Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____
Do you have Medicare Insurance? Y N Plan /Group #: _____
☐ Insurance and/or Medicare card copied by Office Staff ☐ Drivers license copied by Office Staff
Primary Care Physician name: _____ May we notify them of your progress? Y N
How did you hear about our clinic? Whom may we thank for referring you? _____

Notice of Patient Privacy Rights

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Chapel Hill Chiropractic Centre to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Chapel Hill Chiropractic Centre to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Signature: _____ **Date:** _____

Spouse's or Guardian's Signature: _____ Date: _____

HEALTH CONCERNS: Please list your top health concerns in order of priority.

- 1) _____
- 2) _____
- 3) _____
- 4) _____

TREATMENT: What type of treatment are you looking for?

- ☐ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
- ☐ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
- ☐ I am looking to take care of my problem and then go on to "achieve optimal health and wellness."

COMPLAINT/PROBLEM: In relation to your primary complaint:

When did you first seek treatment for this problem? _____

Has another doctor(s) treated you for this condition: Y N If yes, whom? _____

Treatment(s): _____

Have you had any intolerance or reactions to treatments? Y N

Describe: _____

If this is a recurrence, when was the first time you noticed this problem? _____

How did it originally occur? _____ Has it become worse recently? Y N ☐ Same ☐ Better ☐ Gradually worse

How frequent is the condition? ☐ Constant ☐ Daily ☐ Intermittent ☐ Night only How long does it last? ☐ All day ☐ Few hours ☐ Minutes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation ☐ Other : _____

How long has it been since you really felt good? ☐ Days ☐ Weeks ☐ Months ☐ Years ☐ >10 years

Describe the pain: ☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing ☐ Other: _____

What makes the problem worse? ☐ Standing ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting .Other: _____

Is there anything that you can do to relieve the problem? .Y .N If yes, describe: _____

If no, what have you tried to do that has not helped? _____

What do you believe is wrong with you? _____

Are there any other conditions or symptoms that may be related to your major symptom? ☐ Y ☐ N If yes, what? _____

Have you been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Describe: _____

Please check all of the symptoms that apply. (P=Past / C= Current)

P / C

- ☐ Headache
- ☐ Facial Pain
- ☐ Eye Pain
- ☐ Blurred Vision
- ☐ Dizziness
- ☐ Earache
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Sinusitis
- ☐ Teeth Grinding
- ☐ Dry Mouth
- ☐ Excessive Thirst
- ☐ Unpleasant Taste
- ☐ Neck Pain
- ☐ Sore Throat
- ☐ Lump in Throat
- ☐ Swallowing Pain
- ☐ Unsteady Voice
- ☐ Shoulder Pain
- ☐ Persistent Coughing
- ☐ Chest Pressure
- ☐ Slow Heart Rate
- ☐ Rapid Heart Rate

P / C

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Abdominal Pains
- ☐ Nausea/Vomiting
- ☐ Poor Appetite
- ☐ Fullness of Bladder
- ☐ Urination Difficulty
- ☐ Frequent Urination
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Decreased Sex Drive
- ☐ Menstrual Irregularities
- ☐ Elbow / Hand Pain
- ☐ Tingling in Hands
- ☐ Clammy Hands
- ☐ Low Back Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Poor Circulation
- ☐ Swollen Joints
- ☐ Joint Stiffness
- ☐ Swollen Ankles
- ☐ Ankle / Foot Pain

P / C

- ☐ Tingling in Feet
- ☐ Walking Problems
- ☐ Sore Muscles
- ☐ Weak Muscles
- ☐ Paralysis
- ☐ Shakiness
- ☐ Sweating
- ☐ Insomnia
- ☐ Fainting
- ☐ Convulsions
- ☐ Irritability
- ☐ Impatience
- ☐ Fatigue
- ☐ Feel Loss of Control
- ☐ Other: _____

Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

Stabbing/Cutting - |||

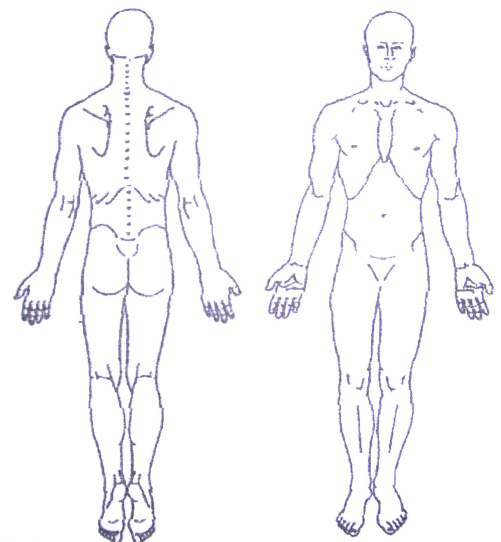
Tingling - :::

Burning - XXX

Cramping - ^^^

Numbness - ===

Dull - ###



ALLERGIES: Please check and list all allergies.

- ☐ Food: _____
- ☐ Medications: _____
- ☐ Seasonal /Other: _____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	Date Started
☐ Antacids		
☐ Antibiotics		
☐ Antidepressants		
☐ Anti-Diabetics		
☐ Anti-Inflammatory		
☐ Blood Pressure Lowering Meds.		
☐ Cholesterol Lowering Meds.		
☐ Hormone Replacements (HRT)		
☐ Oral Contraceptives		
☐ Other		

SCARS / SURGICAL PROCEDURES: List all scars and surgical procedures you have had.

SUPPLEMENTS: Do you take Vitamins/Supplements or Herbs? ☐ Y ☐ N If yes, who recommended them? _____

<u>HABITS:</u>	Heavy	Moderate	Light	None		5-7x/wk	3-5x/wk	1-3x/wk	None	Type	Time
Alcohol	☐	☐	☐	☐	<u>Exercise</u>	☐	☐	☐	☐		
Coffee	☐	☐	☐	☐		8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs	
Soda/Diet Soda	☐	☐	☐	☐	<u>Sleep</u>	☐	☐	☐	☐	☐	
Tobacco	☐	☐	☐	☐		5+	4	3	2		
Drugs	☐	☐	☐	☐	<u>Meals / day</u>	☐	☐	☐	☐		
Stress Level	☐	☐	☐	☐		64+oz	32-64oz	16-32oz	<8oz		
					<u>Water / day</u>	☐	☐	☐	☐		

WORK ACTIVITY: ☐ Heavy Labor ☐ Light Labor ☐ Mostly Sitting ☐ Mostly Standing ☐ Walking / Moving ☐ Driving

FAMILY HISTORY: Identify any conditions that you, or any of your family members have now or have had in the past:
(G = Grandparents, M = Mother, F = Father, S = Siblings, X = Self)

___ Alcoholism	___ Eczema	___ Miscarriage(s)	___ Tumor(s)
___ Anemia	___ Emphysema	___ Mumps	___ Ulcer(s)
___ Cancer	___ Epilepsy	___ Pleurisy	___ Other: _____
___ Cold sores	___ Goiter	___ Pneumonia	_____
___ Deep vein thrombosis	___ Gout	___ Polio	_____
___ Detached retina	___ Heart disease	___ Rheumatic fever	
___ Diabetes	___ HIV / AIDS	___ Stroke	

Patient's Printed Name

Patient's Signature

Date