

White Chiropractic

Date _____

Patient Entrance Form

Name _____ Phone () _____ Social Security # _____

Address _____ City _____ State _____ Zip code _____

Age _____ Birthdate ____/____/____ Gender: M / F No. Children _____ Cell Phone () _____

Marital Status: Single Married Widowed Separated Divorced

Occupation _____ Employer _____ Work Phone () _____

Name of Policy Holder _____ Policyholders SS # _____

Policyholder's date of birth _____ Employer of Policyholder _____

Emergency Contact _____ Phone () _____ Relationship _____

How did you hear about us? : Money Mailer Internet Yellow Pages Other (name of person) _____

Patient's Primary Care Physician (PCP) _____ Phone () _____

Date of Last Physical Exam _____

Are you pregnant? Yes No Uncertain

Please describe your current problem _____

Is your current problem the result of: Auto Accident? Yes No Work Accident? Yes No Slip & Fall? Yes No

How did your problem begin _____

Date Problem began _____ Other doctors seen for this condition _____

List other treatments or tests you've had for this condition _____

Have you been treated for any other health condition by a physician in the last year? Yes No If yes, please explain: _____

How often are your symptoms present? Constantly Frequently Occasionally Intermittently

Describe your current pain/symptoms: Sharp/Stabbing Burning Throbbing Shooting Tingling Gripping
 Dull Numbness Soreness Aches Weakness Other _____

Since it began, is your problem: Improving Getting Worse No Change

What makes the problem better? Nothing Lying Down Standing Walking Sitting Movement
 Exercise Inactivity/Rest Other _____

What makes the problem worse? Nothing Lying Down Standing Walking Sitting Movement
 Exercise Inactivity/Rest Other _____

Can you perform your daily home activities: Yes Only with help Not at all

Do you exercise? Yes, almost daily Yes, occasionally Not at all

Describe your job requirements: Mainly Sitting Light Labor Heavy Labor

Can you perform your daily work activities: Yes, all activities Only some Not at all

Describe your stress level: None to mild Moderate High

EMAIL: _____

Patient Health Questionnaire

Patient Name _____

Please check all that apply. Knowledge of these conditions may influence the type of treatment/therapy you receive.

- | | | |
|--|---|--|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pregnancies |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Swelling, Stiffness of Joints |
| <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Liver/Gallbladder Problems | <input type="checkbox"/> Tinnitus (Ear Noises) |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Vision Disturbances |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Pain - Neck | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Pain - Mid Back | Height: _____ feet _____ inches |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Pain - Low Back | Weight: _____ pounds |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Pain - Arm/Elbow | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pain - Hand | <input type="checkbox"/> Smoking - Packs/Day _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pain - Wrist | <input type="checkbox"/> Alcohol - Drinks/Week _____ |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Pain - Shoulder | <input type="checkbox"/> Coffee/Caffeine Drinks - Cups/Day _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pain - Ankle or Foot | <input type="checkbox"/> Alcohol Dependence |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pain - Leg | <input type="checkbox"/> Drug Dependence |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pain - Knee | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> PMS | |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Prostate Problems | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rapid Heartbeat | |

Please list all allergies including allergies to medications _____

List all medications you are presently taking (including vitamins & supplements) _____

List any bone and/or joint surgeries _____

List any recent Surgeries _____

Family Health History:

If a family member has had any of the following, please mark the appropriate box:

- | | | | | |
|-------------------------------------|-----------------------------------|---|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chronic Headaches |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lupus | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Chronic Back Problems | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Alcoholism | Other _____ | | | |

I certify that all the above personal health information, on pages one and two, is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition in the future.

Patient or Guardian Signature _____ Date _____

*
WHITE CHIROPRACTIC

HEALTH CARE AUTHORIZATION FORM

Patient's Name _____ Patient's SS# _____ Date of Birth _____
Please Print

Signature of Patient _____ Signature of Representative _____
Relationship to Patient: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES WHITE CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATION

- I give permission to White Chiropractic to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives or other health related information.
- If White Chiropractic contacts me by phone, I give them permission to leave a phone message with a member of my household, on my answering machine or voice mail. I give them permission to call my insurance company to verify my Chiropractic benefits.
- I give White Chiropractic permission to disclose my health information to another health care provider or a hospital if it is necessary to refer me to them for the diagnosis, assessment, or treatment of my health condition.
- I give White Chiropractic permission to disclose my health information and billing records to another party if they are potentially responsible for the payment of my services.
- By signing this form you are giving White Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION: This notice is effective as of (today's date): _____. This Authorization shall expire seven years after the date on which you last received services from White Chiropractic.

RIGHT TO REVOKE AUTHORIZATION: You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. The written notice must contain the following information:

- Your name, Social Security number and date of birth
- A clear statement of your intent to revoke this AUTHORIZATION
- The date of your request
- Your signature

White Chiropractic requests this AUTHORIZATION for its own use/disclosure of Private Health Information. (Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, White Chiropractic will not refuse to provide you treatment. You have the right to inspect or copy the Private Health Information to be used/disclosed.

* * A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU * *

***WHITE CHIROPRACTIC**

**Assignment and Instruction for Direct Payment to Doctor
Private and Group Accident and Health Insurance**

Patient: _____ Date: _____
Please print

Person responsible for payment: _____ Employer: _____
Claim/Group # : _____ SS/ID # : _____

I hereby instruct and direct the _____ Insurance
Enter name of your insurance company here
Company, to pay by check made out and mailed directly to:

**White Chiropractic
122 Gateway Blvd
Suite 100
 Mooresville, NC 28117**

I direct you to pay the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **This is a direct assignment of my rights and benefits under this policy.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered effective and valid as the original.

I also authorize the release of any medical information, or otherwise, pertinent to my case To any insurance company, adjuster, or attorney involved in this case.

Print Name of Policyholder Date

Print Name of Representative Date

Signature of Policyholder Date

Signature of Representative Date

Informed Consent to Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;
- b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;
- c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Patient Signature (or Legal Guardian)

Patient Name: _____
(please print)