Spring Lake Chiropractic

Patient Welcome Forms

1171 N. Bragg Blvd., Spring Lake, NC 28390

Phone: (910)436-5000 Fax:(910)436-7705

PATIENT INFORMATION

Today's Date: .....

Name: .....

Date of Birth: .....

Address: ..... City: .....

State: ..... Zip: .....

Home Phone: ..... Cell Phone: .....

Social Security #: ..... Age: ..... ☐ Male ☐ Female ☐ Non-Binary

Email Address: .....

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Other .....

Emergency Contact: ..... Phone: ..... Relationship: .....

Your Occupation: ..... Your Employer: .....

Referred to this Office by: ☐ Friend/Family Member - Name .....

☐ Mail ☐ Clinic Location ☐ Other .....

Preferred language spoken: . ENGLISH .....

Ethnicity: Hispanic or Latino/Mexican/African-American/White/Asian/Other: .....

Are you a smoker? NO

Payment Method: VA Authorizatic Insurance Company: .....

Subscriber ID: ..... Group #: .....

Assignment and Release:

I certify that I, and/ or my dependents have insurance coverage with _____ and assign directly to Spring Lake Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I'm financially responsible for all charges whether or not pain by insurance. I authori ze the use of my signature on all insurance submissions.

Spring Lake Chiropractic may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent ends when my current treatment plan is completed or for one year from the date below.

.....

Printed name of patient and/ or guardian

....

Signature of Patient and/ or Guardian Date Relationship to Patient

FAMILY MEDICAL HISTORY:

S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes)

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	Dislocated joints	☐	☐	☐	Neck pain
☐	☐	☐	Anemia	☐	☐	☐	Epilepsy	☐	☐	☐	Nervousness
☐	☐	☐	Arthritis	☐	☐	☐	German measles	☐	☐	☐	Numbness
☐	☐	☐	Asthma	☐	☐	☐	Headaches	☐	☐	☐	Polio
☐	☐	☐	Back pain	☐	☐	☐	Heart trouble	☐	☐	☐	Poor circulation
☐	☐	☐	Bladder trouble	☐	☐	☐	Reproductive disorders	☐	☐	☐	Hepatitis
☐	☐	☐	Bone fracture	☐	☐	☐	High blood pressure	☐	☐	☐	Rheumatic fever
☐	☐	☐	Cancer	☐	☐	☐	HIV / ARC	☐	☐	☐	Rheumatism
☐	☐	☐	Chest pain	☐	☐	☐	Kidney disorder	☐	☐	☐	Scarlet fever
☐	☐	☐	Concussion	☐	☐	☐	Bowel control loss	☐	☐	☐	Serious injury
☐	☐	☐	Convulsions	☐	☐	☐	Menstrual cramps	☐	☐	☐	Sinus trouble
☐	☐	☐	Diabetes	☐	☐	☐	Multiple sclerosis	☐	☐	☐	Tuberculosis
☐	☐	☐	Indigestion	☐	☐	☐	Muscular dystrophy	☐	☐	☐	Venereal disease

SURGICAL HISTORY

1. ..... Date: .....

2. ..... Date: .....

3. ..... Date: .....

Have you ever had a metal implant? ☐ Yes ☐ No

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS: *(Please rate your symptoms 1-10, with 1 being the least serious)*

Rating

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

Symptoms are worse in ☐ Morning ☐ Afternoon ☐ Night

When and how occured? .....

.....

Symptoms developed from: ☐ Job related injury ☐ Autoaccident ☐ Other

☐ Accident ☐ Illness ☐ Unknown cause ☐ Gradual onset Date occurred: .....

Symptoms have persisted for # ..... Hour(s) ..... Day(s) ..... Week(s) ..... Month(s) ..... Year(s)

Symptoms/Complaints: ☐ Come & go ☐ Are constant

Have you ever had this before: ☐ No ☐ Yes When? .....

If you were to guess, what do you think is causing your complaints? .....

.....

Name and location of doctors previously seen for present conditions(s) .....

.....

Are you allergic to any medications: ☐ No ☐ Yes What kind? .....

Are you taking any medications: ☐ No ☐ Yes What kind? .....

Are you pregnant ☐ No ☐ Yes Date of last period .....

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **AGGRAVATE** YOUR CONDITION:

☐ Bending ☐ Reaching ☐ Straining at stool ☐ Coughing ☐ Sitting ☐ Turning head
☐ Lifting ☐ Sneezing ☐ Walking ☐ Lying down ☐ Standing

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **RELIEVE** YOUR CONDITION:

☐ Bending ☐ Sitting ☐ Lifting ☐ Standing ☐ Lying down ☐ Turning head ☐ Reaching
☐ Walking

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:

☐ Blurred vision ☐ Buzzing in ears ☐ Cold feet ☐ Cold hands ☐ Cold sweats ☐ Concentration loss/Confusion
☐ Constipation ☐ Depression/Weeping spells ☐ Diarrhea ☐ Dizziness ☐ Face flushed ☐ Fainting
☐ Fatigue ☐ Fever ☐ Head seems too heavy ☐ Headaches ☐ Insomnia ☐ Light bothers eyes ☐ Loss of balance
☐ Loss of smell ☐ Loss of taste ☐ Low resistance to colds ☐ Muscle jerking ☐ Numbness in fingers
☐ Pins and needles in arms ☐ Stiff neck ☐ Pins and needles in legs ☐ Ringing in ears ☐ Shortness of breath
☐ Stomach upset

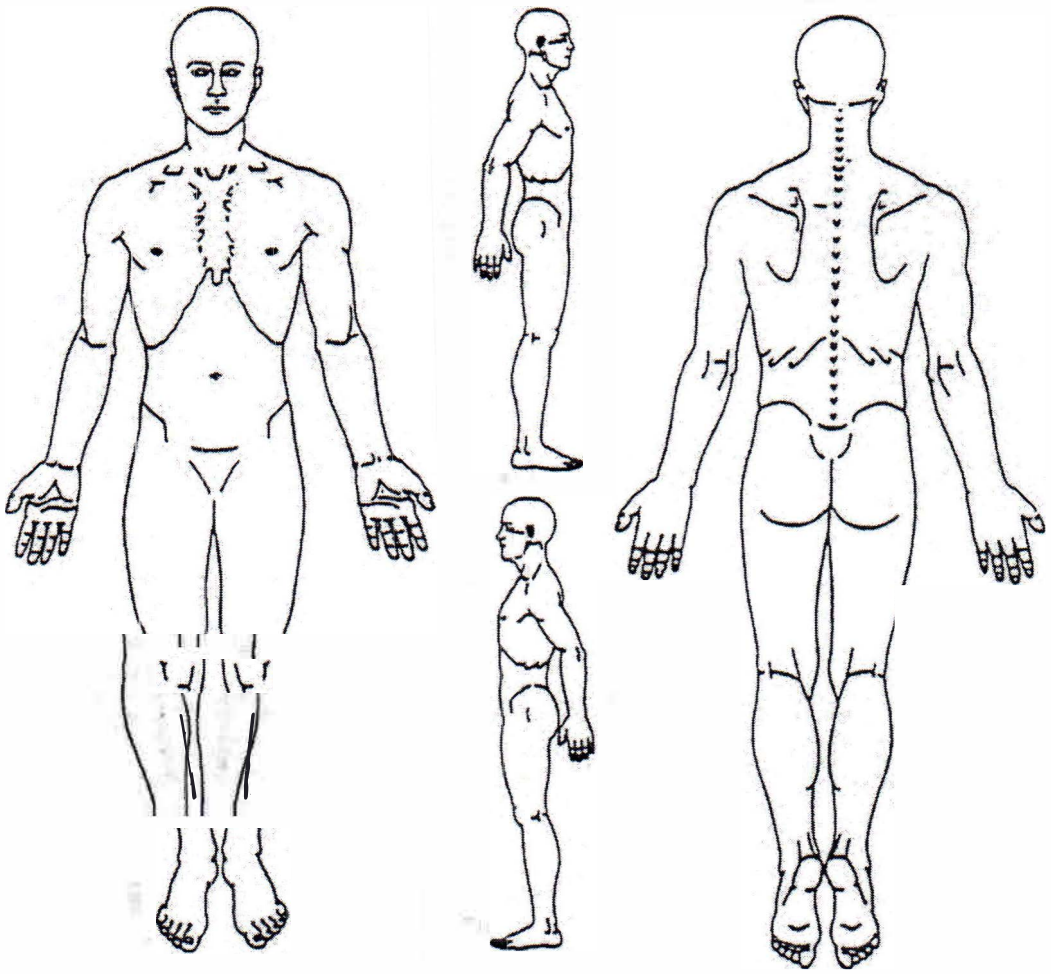
Patient Signature: ..... Date: .....

PAIN DIAGRAM

Name: . . . . . Date: . . . . . .
How long have you had pain? . . . . . Years . . . . . Months . . . . . Weeks

On the diagram below, please indicate exactly where your pain is located. By using the key, please indicate the type of pain your having in that region. Rate your pain on a scale of 1-10 using the chart below.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain



A = Aching	B = Burning
N = Numbness	P = Pins & Needles
S = Stabbing	O = Other

Spring Lake Chiropractic

INFORMED CONSENT FORM

1171 N. Bragg Blvd. Spring Lake, NC
910-436-5000

PATIENT NAME: _____ DATE: _____

Please read this entire document prior to signing it.
It is important that you understand the information contained in this document.
If anything is unclear, please ask questions before you sign.

The nature of chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic Medicine is spinal manipulative therapy. I will use this procedure to treat you. I may use my hands, or a medical instrument in such a way as to move your joints. Adjustment may cause an audible "pop" or "click", much as you may have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

Spinal Manipulative Therapy	Basic Neurological Testing	Electrical Stim
Palpation	Muscle Strength Testing	Possible others:
Vital Signs	Postural Analysis	_____
Range of Motion Testing	Hot/Cold Therapy	_____
Orthopedic Testing	Possible Mechanical Traction	_____

The material risks inherent in chiropractic adjustment:

As with any healthcare procedure, there are certain complications which may arise during chriopractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contradictions to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-Ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are one in five million cervical adjustments. The other complications are also generally described as rare.

PLEASE CONTINUE TO READ & SIGN >

The availability and nature of other treatment options:

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs, such as anti-inflammatory, muscle relaxants, and painkillers
- Hospitalization
- Surgery

If you chose to use one of the above treatment options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduced mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment by making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.

PATIENT CONSENT

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Driscoll and have had my questions answered to my satisfaction.

By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Today's Date _____

Patient's Name _____

Signature _____

Signature _____
of Parent or Guardian (if a minor)

Today's Date _____

Doctor's Name Dr. Tina M. Driscoll

Signature _____

Signature _____
of Parent or Guardian (if a minor)

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PATIENT RECORD OF DISCLOSURES

1171 N. Bragg Blvd. Spring Lake, NC
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In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone _____
  - ☐ It's okay to leave a message with detailed information.
  - ☐ Leave a message with call back information only.
- ☐ Work Telephone _____
  - ☐ It's okay to leave a message with detailed information.
  - ☐ Leave a message with call back information only.
- ☐ Written Communication
  - ☐ It's okay to mail to my home address.
  - ☐ It's okay to mail to my work/office address.
  - ☐ It's okay to fax to this number: _____
- ☐ Other _____

Patient Name _____ Today's Date _____

Patient Signature _____ Birthdate _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for, PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom and Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	Disclosed by Whom	(2)	(3)

(1) Check this box if the disclosure is authorized.
(2) Type Key: T= Treatment Records, P= Payment Information, O= Healthcare Operations
(3) Enter how the disclosure was made: F= Fax, P= Phone, E= Email, M= Mail, O= Other

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HIPAA PRIVACY NOTICE

1171 N. Bragg Blvd. Spring Lake, NC
910-436-5000

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

PATIENT NAME: _____

SIGNATURE: _____

TODAY'S DATE: _____

FOR OFFICE USE ONLY

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the Acknowledgment
- ☐ An emergency situation prevented us from obtaining Acknowledgment
- ☐ Other (Please Specify) _____

_____

_____

Staff Signature _____ Today's Date _____

Spring Lake Chiropractic

NECK INDEX

1171 N. Bragg Blvd. Spring Lake, NC
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Patient Name _____ Date _____

This questionnaire will give your provider information about how your neck condition affects your everday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain comes and goes and is moderate.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Personal Care

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but I manage most of my personal care.
- I need help every day in most aspects of personal care.
- I do not get dressed, I wash with difficulty, and stay in bed.

Sleeping

- I have no trouble sleeping.
- My sleep is slightly distrubed (less than 1 hour sleepless).
- My sleep is midly disturbed (1 - 2 hours sleepless).
- My sleep is moderately disturbed (2 - 3 hours sleepless).
- My sleep is greatly disturbed (3 - 5 hours sleepless).
- My sleep is completely disturbed (5 - 7 hours sleepless).

Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight neck pain.
- I can drive my car as long as I want with moderate neck pain.
- I cannot drive my car as long as I want because of moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I cannot drive my car at all because of neck pain.

Reading

- I can read as much as I want with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I cannot read as much as I want because of neck pain.
- I can hardly read at all because of sever neck pain.
- I cannot read at all because of neck pain.

Recreation

- I am able to engage in all my recreational activities without neck pain.
- I am able to engage in all my usual recreational activities with some neck pain.
- I am able to engage in most but not all my usual recreation activities because of neck pain.
- I am only able to engage in a few of my usual recreational activities because of neck pain.
- I can hardly do any recreational activities because of neck pain.
- I cannot do any recreational activities because of neck pain.

Concentration

- I can concentrate fully when I want with no difficulty.
- I can concentrate fully when I want with slight difficulty.
- I have a fair degree of difficulty concentrating when I want.
- I have a lot of difficulty concentrating when I want.
- I have a great deal of difficulty concentrating when I want.
- I cannot conctrate at all.

Headaches

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently
- I have severe headaches which come frequently.
- I have headaches almost all of the time.

Work

- I can do as much work as I want.
- I can only do as much as my usual work but no more.
- I can only do most of my usual work but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (e.g. on a table).
- Pain prevents me from lifting heavy weights off the floor but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights.

Index Score: [Sum of all statements selected, (number of sections with a statement selected x 5)] x 100

Spring Lake Chiropractic

BACK INDEX

1171 N. Bragg Blvd. Spring Lake, NC
910-436-5000

Patient Name _____ Date _____

This questionnaire will give your provider information about how your back condition affects your everday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is very severe.
- The pain is very severe and does not vary much.

Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow.
- My pain is neither getting better or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Sleeping

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of my pain, my normal sleep is reduced by less than 25%.
- Because of my pain, my normal sleep is reduced by less than 50%.
- Because of my pain, my normal sleep is reduced by less than 75%.
- Pain prevents me from sleeping at all.

Sitting

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sittin gmore than 1 hour.
- Pain prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting more than 15 minutes.
- I avoid sitting because it increases pain immediately.

Standing

- I can stand as long as I like without pain.
- I have some pain while standing but it does not increase with time.
- I cannot stand longer than 1 hour without increasing pain.
- I cannot stand longer than 1/2 hour without increasing pain.
- I cannot stand longer than 15 minutes without increasing pain.
- I avoid standing because it increases pain immediately.

Traveling

- I get no pain while traveling.
- I get some pain while traveling but none of my usual forms of travel make it worse.
- I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- I get extra pain while traveling which causes me to see alternate forms of travel.
- Pain restricts all forms of travel except that done while lying down.
- Pain restricts all forms of travel.

Walking

- I have no pain while walking.
- I have some pain while walking but it doesn't increase with distance.
- I cannot walk more than 1 mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

Personal Care

- I do not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain but I manage not to change my way of doing it.
- Washing and dressing increases the pain but I find it necessary to change my way of doing it
- Because of the pain, I am unable to do some washing and dressing without help.
- Beacuse of the pain, I am unable to do any washing and dressing without help.

Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increased the degree of pain.
- Pain has no significant affect on my social life apart from limiting my more energetic interests (eg., dancing, etc).
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I hardly have any social life because of pain.

Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (e.g., on a table).
- Pain prevents me from lifting heavy weights off the floor but I can manage light to medium
- weights if they are conveniently positioned.
  I can only lift very light weights.

Index Score: [Sum of all statements selected, (number of sections with a statement selected x 5)] x 100