FAMILY CHIROPRACTIC CENTER OF SANFORD
1100 CARTHAGE STREET
919-775-2114 FAX 919-776-4032

Date: _____

Full Name: _____ **Nickname:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone: _____ **Home Phone:** _____ **Work Phone:** _____

Cell Phone: _____ **Email:** _____

Do we have permission to leave messages at the phone numbers provided (circle): YES NO

Appointment Reminder by: TEXT or EMAIL (circle one or both)

Birth Date: _____ **Sex: M F SSN:** _____ **Marital Status: S M D W**

Spouse Name: _____

Referral Source (if applicable): _____

Emergency Contact: _____ **Emergency Phone:** _____

Insurance Company: _____ **Attorney:** _____

Employer: _____ **Occupation:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **Email:** _____

Have you been seen by other Doctor for this condition? YES NO If yes, who? _____

Have you missed any work due to this condition? YES NO When? _____

How did you hear about our office? _____

This information will be used to protect your health records ...please answer ALL questions.

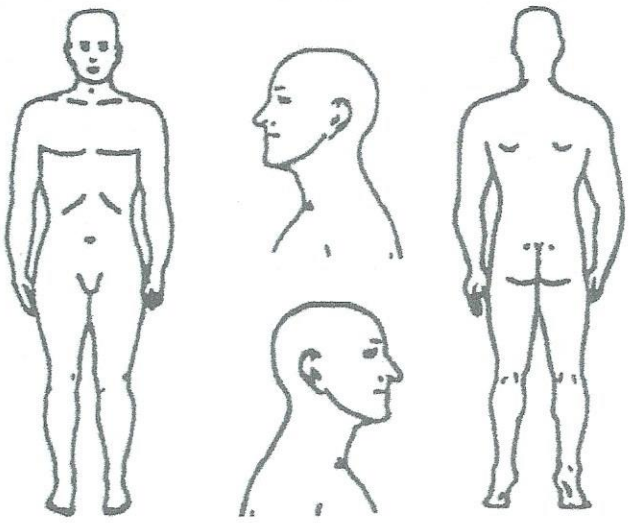
COMPLAINTS

FAMILY CHIROPRACTIC CENTER OF SANFORD
1100 CARTHAGE STREET
SANFORD, NORTH CAROLINA 27330

Date: _____

Patient Name: _____ DOB: _____

PLEASE MARK YOUR AREAS OF PAIN BELOW....



_____

_____

_____

_____

_____

_____

_____

_____

What is your major complaint? _____

Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

Have you had this condition in the past? YES NO

Please rate your pain on a scale of 1 to 10 (0 = no pain and 10 = excruciating pain) 1 2 3 4 5 6 7 8 9 10

Describe the nature of your symptoms:

____Burning ____Dull Ache ____Numb ____Radiating Pain ____Sharp ____Shooting ____Stabbing Pain

____Tightness ____Tingling ____Throbbing ____Sore ____Stiff ____Aggravating ____Nagging ____

____Aching ____Pinching ____ Irritating

How often do you experience your symptoms?

____Constantly (76-100% of the day ____Frequently (51-75% of the day)

____Occasionally (26-50% of the day) ____Intermittently (0-25% of the day)

How do your symptoms affect your ability to perform daily activities such as working or driving?

(O= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition or you are unable to do (working, exercise, etc.)? _____

What makes your pain better (ice, heat, massage, etc.)? _____

What activities are you not able to do? _____

HISTORY: Recent Falls: Y N Recent Surgeries: Y N Recent Accidents: Y N

Doctor's Comments: _____

_____

_____

QUICKCHARTS PATIENT CASE HISTORY

Name: _____ DOB _____
Date: _____

List any Allergies: None

D Animals D Aspirin D Bees D Chocolate D Dairy D Dust D Eggs D Latex D Molds D Penicillin D Ragweed/Pollen

D Rubber D Seasonal Allergies D Shellfish D Soaps D Wheat D X-Ray Dye D Other: _____

List any Surgeries: None

D Back D Brain D Elbow D Foot D Hip D Knee D Neck D Neurological D Shoulder D Wrist D Other: _____

List ALL Past Medical History conditions:

D Ankle Pain D Arm Pain D Arthritis D Asthma D Back Pain D Broken Bones D Cancer D Chest Pain D Depression

D Diabetes D Dizziness D Elbow Pain D Epilepsy D Eye Vision Problems D Fainting D Fatigue D Foot Pain

D Genetic Spinal Condition D Hand Pain D Headaches D Hearing Problems D Hepatitis D High Blood Pressure

D Hip Pain D HIV D Jaw Pain D Joint Stiffness D Knee Pain D Leg Pain D Menstrual Problems D Mid-Back Pain

D Minor Heart Problem D Multiple Sclerosis D Neck Pain D Neurological Problems D Pacemaker D Parkinson's

D Polio D Prostate Problems D Shoulder Pain D Significant Weight Change D Spinal Cord Injury D Sprain/Strain

D Stroke/Heart Attack D Other: _____

List Type of Medications you are taking and reason:

D Anxiety D Muscle Relaxers D Pain Killers D Insulin D Birth control D Cardiovascular D Allergy D Seizure

D Other: _____

List your Family History:

D Arthritis D Asthma D Back Pain D Cancer D Depression D Diabetes D Epilepsy D Genetic Spinal Condition

D High Blood Pressure D Heart Problems D Multiple Sclerosis D Neurological Problems D Parkinson's D Polio

D Prostate Problems D Stroke/Heart Attack D Other: _____

Have you had any auto or other accidents? D No D Yes

Describe: _____

Date of last physical examination: _____

Do you smoke? D No D Yes

Do you drink alcohol? D No D Yes - how many per day? _____

Do you drink caffeine? D No D Yes - how many per day? _____

Do you exercise? D No D Yes (what forms and how often): _____

Main reason for consulting the office:

Become pain free

Explanation of my condition

Learn how to care for my condition

Reduce symptoms

Resume normal activity level

Family Chiropractic Center of Sanford
1100 Carthage Street
Sanford, NC 27330
(919) 775-2114 (919) 776-4032

Family Chiropractic Center of Sanford is required by law and in compliance with HIPAA to maintain the confidentiality of your protected health information and to provide patients with notice of privacy practices with respect to health records.

We may disclose healthcare information to other healthcare professionals within our practice for the purpose of treatment and healthcare. It is our policy to provide another healthcare provider for your treatment during our absence.

We may disclose your health information to your insurance company for the purpose of payment. As a courtesy, we will submit an itemized statement to your insurance company for the purpose of payment for services rendered. These itemized statements include diagnosis, date of injury or condition, codes describing services rendered and charges.

Health information for patients treated under Worker's Compensation may be disclosed as necessary to comply with State Workers' Compensation Laws.

We may disclose health information to another healthcare provider in response to your referral to or from our office.

We may contact you by mail or e-mail to provide appointment reminders or information about treatment, alternate treatment or other health benefits, birthday cards, holiday cards, periodic announcements and services that may be of interest to you.

In emergencies, we may disclose your health information to notify or assist in notifying a family member or other individual responsible for your care.

As required by law, we may release health information to public health authorities for purposes of preventing or controlling disease, injury or disability, reporting child abuse or neglect, domestic violence and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding, law enforcement official, complying with a court order or subpoena or other law enforcement purpose.

As a courtesy, we may call your home or leave a message, starting your next appointment date and time or missed appointments.No personal health information will be disclosed.

Your name can be listed on our Birthday Board and/or our Superstar Referral Board.

You have the right to request restriction on certain uses and disclosures of your health information. If you have such a request, please notify Family Chiropractic Center of Sanford immediately with the restrictions.

You have the right to inspect and receive a copy of your health information. Further, you have a right to request that Family Chiropractic Center of Sanford amend your health information but they are not required to agree to amend it. If your request is denied, you will be given an explanation of denial reasons and how you can disagree with the denial.

Patient Name _____ Patient DOB _____

FAMILY CHIROPRACTIC CENTER OF SANFORD
1100 CARTHAGE STREET
919-775-2114 FAX 919-776-4032

Name: _____Date of Birth: _____

You have a right to receive an accounting of disclosures of your health information made by Family Chiropractic Center of Sanford.

Family Chiropractic Center of Sanford is required by law to maintain the privacy of your health information. If you have any questions regarding this notice, you may contact the Privacy Officer by calling (919) 775-2114. If you need to make an appointment with the Privacy Officer you may do so by telephone or in person. If you are not satisfied with the way your complaint is handled, you may request the address to file a formal complaint.

If you witness any perceived discrepancy or possible violation concerning HIPAA, you must report it to the Privacy Officer.

We must disclose your health information to DHHA as necessary for them to determine our compliance with HIPAA standards.

I have read the Privacy Notice and understand my rights contained in the notice.

I provide Family Chiropractic Center of Sanford with my authorization and consent to use my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Printed Patient Name or Guardian Name

_____ _____
Signature of Patient or Guardian Date

I authorize release of any medical information or other information necessary to process any claim.

_____ _____
Signature of Patient or Guardian Date

Further, I authorize payment of medical benefits for services rendered be made payable to Family Chiropractic Center of Sanford.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Authorized Office Signature Date

Informed Consent for Chiropractic Treatment

FAMILY CHIROPRACTIC CENTER OF SANFORD
1100 CARTHAGE STREET
SANFORD, NORTH CAROLINA 27330

Patient Name: _____ **DOB:** _____

To the Patient

Please read this **entire** document prior to signing. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The Nature of the Chiropractic Adjustment

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

Analysis/ Examination/ Treatment

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

Spinal Manipulative Therapy	Palpation	Vital Signs
Range of Motion Testing	Orthopedic Testing	Postural Analysis
Basic Neurological Testing	Ultrasound	Hot/Cold Therapy
Muscle Strength Testing	Radiographic Studies	EM

The Material Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic 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 contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The Probably 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 exceedingly rare and are estimated to occur one in one million and one in five million cervical adjustments. The other complication are also generally described as rare.

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 relaxers, and pain killers.
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatments" 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 Danger Attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment 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 Block and Sign Below.

I have read { } or have had read to me { } the above explanation of the Chiropractic Adjustment and Related Treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved and 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 that treatment.

Date: _____

_____
Patient' Name

_____
Signature

_____
Signature of Parent or Guardian (if minor)

Date: _____

_____
Doctor's Name

_____
Signature

_____
Date of Birth

FAMILY CHIROPRACTIC CENTER OF SANFORD
1100 CARTHAGE STREET
SANFORD, NORTH CAROLINA 27330

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Family Chiropractic Center of Sanford or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Also I have received a copy of Notice of Privacy Practices updated January 2017.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

Authorization and Assignment

To: Family Chiropractic Center of Sanford, P. A.
1100 Carthage Street, Sanford, North Carolina 27330

In consideration of your undertaking to treat me, I agree to the following:

Authorization to Release information

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

Assignment of Cause of Action

In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the 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 is/are believed to 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 compromise, settle of otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due), I personally owe you, and agree to pay in a current manner.

Authorization to Pay Directly to Doctor

To: _____
(Name of attorney and/ or insurance company)

In consideration of the chiropractic services rendered and to be rendered by him I authorize and direct the payment to the doctor named above of any sum I now or hereafter owe him by you, my attorney, out of the proceeds of any settlement of *my* case, and/ or by any insurance company obligated to reimburse me for the charges for his services or otherwise obligated to reimburse me for the charges for his services or otherwise obligated to make payment to me or him based in whole of in part upon the charges made for his services .

Acknowledgement and Understanding

I hereby acknowledge that I am receiving (or about to receive) health care services at the Family Chiropractic Center of Sanford office, and that I have been advised that the doctor(s) providing the services is/ are willing to wait for payment for these services, provided that these services, provided that there continues to be b reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that if it is determined either:

(1) That there is no insurance company obligated to pay for the services, of if the insurance company involved refuses to acknowledge an assignment to the doctor(s) or make other provisions for the protection of the interest of the doctor(s) ; or
(2) If a liability claim exists, or my attorney refuses to agree to protect the interest of the doctor(s), or if I have not engaged the services of an attorney;

Then payment for services rendered by the doctor(s) at the Family Chiropractic Center of Sanford office will be made on a current basis and *my* bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever comes first.

_____ _____
Patient's Name Date of Birth

_____ _____
Patient's Signature Date

_____ _____
Witness Date

Family Chiropractic Center of Sanford
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(919) 775-2114 Fax: (919) 776-4032

I, _____confirm that the complaints I have today and
(print name)

for which I am seeking treatment, are not connected with or arising from any work or employment related injury, related to any type of personal injury involving a third party insurance company or an attorney, or is in relationship with any possible disability claim. I further state that I will not be billing any worker's compensation carrier, an attorney or a third party payer for any bills that I incur at Family Chiropractic Center of Sanford.

_____ _____
Name Date of Birth

_____ _____
Signature Date

Family Chiropractic Center of Sanford
1100 Carthage Street
Sanford, NC 27330
(919) 775-2114 Fax: (919) 776-4032

To All New Patients

All insurance will be requested to be made out and mailed to Family Chiropractic Center of Sanford. This includes health insurance, med-pay insurance and the other person's liability insurance. If your expenses at FCC are overpaid, you will be reimbursed for the over payment.

Our bill is expected to be paid first from insurance proceeds. We do not expect to be the last one to wait on our bill to be paid. We will work with you on collecting from the insurance companies involved.

This office will be glad to file your claims for you. Please do not send receipts to the insurance company unless you make arrangements with our insurance department first. We will work with you, asking that you pay your deductible and your percentage. Remember, you are responsible for any amount your insurance does not pay.

Personal Injury: If you engage an attorney to handle your case, (and we do encourage you to engage an attorney) all information will be sent directly to the attorney upon a written request from him stating that he is representing you. No information will be given out concerning your case (not even to you) except directly to your attorney.

We are on computer, and all insurance information must be put in within the first day or two, or the computer will print a claim. If after several days you remember that you have insurance you would like to file with, there will be a $5.00 fee.

There will be a $5.00 fee on all disability forms that you need to have filled out by this office.

Medicare Patients: We are sorry, but we do not accept assignment on Medicare. The patient must pay us and we will be glad to file all your claims and have the insurance company to send the check to you.

Appointments: The doctor will make a schedule concerning the appointments that he believes is necessary in making you well again. You are expected to keep these appointments as scheduled. Please call if you are unable to keep an appointment. If you do not call or show up within 30 minutes of you appointment, you will be called. This puts extra work on us which is unnecessary. If you do not show up for an appointment and we are unable to contact you
within 10 days, you will be terminated from our care. Your case will be closed and all paperwork sent to the proper insurance company.

_____ _____
Name Date of Birth

_____ _____
Signature Date

LOW BACK PAIN QUESTIONNAIRE

FAMILY CHIROPRACTIC CENTER OF SANFORD
1100 CARTHAGE STREET
919-775-2114 FAX 919-776-4032

Patient's Name: _____ **Date:** _____

INSTRUCTIONS: When your back or leg hurts, you may find it difficult to do some of the things you normally do. Please check off the answer that describes you **today.**

Questions	True	False
1. I stay at home most of the time because of my back and/or leg pain.		
2. I walk more slowly than usual because of my back and/or leg pain.		
3. Unable to do work around the house because of back and/or leg pain.		
4. I have to use handrails to get upstairs because of back and/or leg pain.		
5. I lie down to rest more often because of back and/or leg pain.		
6. I have to hold something to get out of a chair due to back and/or leg pain.		
7. I try to get others to do for me because of the back and/or leg pains.		
8. I get dressed more slowly than usual because of back and/or leg pain.		
9. I stand up only short periods of time because of back and/or leg pain.		
10. I try not to bend or kneel down because of back and/or leg pain.		
11. It is difficult to get out of a chair because of back and/or leg pain.		
12. My back is painful almost all the time.		
13. I find it difficult to turn over in bed because of back and/or leg pain.		
14. I have trouble putting on my socks because of pain in back and/or leg		
15. I sleep less well because of my back and/or leg pain.		
16. I avoid heavy jobs around the house because of my back and/or leg pain.		
17. Due to back and/or leg pain, I am more irritable with people than usual.		
18. Because of back and/or leg pain, I go upstairs more slowly than usual.		
19. I must change positions frequently because of back and/or leg pain.		
20. My appetite is not very good because of my back and/or leg pain.		
21. I can only walk short distances because of my back and/or leg pain.		
22. Because of my back and/or leg pain, someone else must help me dress.		
23. I sit down for most of the day because of my back and/or leg pain.		
24. I stay in bed most of the time because of my back and/or leg pain.		

FAMILY CHIROPRACTIC CENTER OF SANFORD
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NECK DISABILITY QUESTIONNAIRE

Patients Name: _____ Date: _____

Please answer each Section by checking the **one** choice that most applies to how you feel.

Section 1: Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is mild at the moment.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain is severe but comes and goes.
- ☐ The pain is severe and does not vary much.

Section 2: Personal Care (Washing, Dressing)

- ☐ I manage personal care without extra pain.
- ☐ My personal care causes extra pain.
- ☐ My personal care is painful, I am slow & careful.
- ☐ I need some help, but manage most of my personal care.
- ☐ I need daily help in most aspects of self-care.
- ☐ I do not get dressed; daily care is difficult, I stay in bed most days.

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting weight of the floor but can if they are positioned on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4: Reading

- ☐ I can read without pain in my neck.
- ☐ I can read with slight pain in my neck
- ☐ I can read with moderate pain.
- ☐ I cannot read much due to moderate pain.
- ☐ I cannot read much due to severe pain.
- ☐ I cannot read at all due to neck pain.

Section 5: Headache

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

Section 6: 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.
- ☐ It is difficult to concentrate.
- ☐ A great deal of difficulty in concentrating.
- ☐ I cannot concentrate at all.

**Please answer more questions on next page

NECK DISABILITY QUESTIONNAIRE

Section 7: Work

- ☐ I can do as much work as I want to.
- ☐ I can do my usual work but no more.
- ☐ I can do some 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.

Section 8: Driving

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

Section 9: Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly 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).

Section 10: Recreation

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