***<u>**Please complete each line on this form or write N/A if the line is not applicable to you.**</u>

Patient Name:____ Sex: ☐ M ☐ F
(FIRST) (MI) (LAST)

Patient DOB: _____________ Marital Status: S M D W

Is the patient a child/minor? ☐ Yes ☐ No If YES, name of parent:_______________________

Address: ____

Cell: ________________________________ Work: _________________________

Email address: __________________________ Home: ________________________

Employment: ☐ Unemployed ☐ Full-time ☐ Part-time ☐ Retired ☐ Student

Present Employer:_____________________________ Occupation:________________

Primary Care Physician:__________________________ Phone: ____________________

Emergency Contact: ____________________________ Phone: ____________________

How did you hear about our practice? ____

Patient Signature: X___________________________________ **Date:** __________

If the patient is a minor, this signature authorizes Cary Family Chiropractic, PLLC to provide care to a minor.

Cary Family Chiropractic, PLLC
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HEALTH INFORMATION

Childhood Years:

Traumatic birth process? ________ Medical problems/Ear infections?______________________________

Falls or other traumas? ____

Adult Years: (Please list dates)

Falls or other traumas? ____

Sports Injuries? ____

Auto Accidents?

#1 Date: ___________ Treatment/Length of Treatment:_______________________________________

#2 Date: ___________ Treatment/Length of Treatment:_______________________________________

****Patient Signature: X**____ **Date:** _____________

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Medications/Reason for taking?

#1: ________________ Reason for taking: ____

#2: ________________ Reason for taking: ____

#3: ________________ Reason for taking: ____

#4: ________________ Reason for taking: ____

Surgeries? Date and type of surgery: ____

____

Pregnancies/dates? ____

Family history/prevalent diseases?____

____

Lifestyle: Alcohol: __________________________ Tobacco: ________________________________

Hobbies:____

Level of exercise: ____

Diet: ____

Stress: Physical (i.e. daily activities, hobbies, repetitive motion, lifting etc.): ______________________

Emotional ☐ None ☐ Low ☐ Moderate ☐ High ☐ Depression ☐ Anxiety

Chemical (i.e. vitamins/supplements, medication, alcohol, lack of water, junk food): _____________

____

What type of work do you do? ____

Do you sit or stand at work? ____

Recreational activities? ____

What position do you sleep in? (Check all that apply) ☐ Back ☐ Stomach ☐ Side

****Patient Signature: X**____ **Date:** _____________

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Have you been to a chiropractor before? ☐ YES ☐ NO **Date of Last visit**? ________________

Length of treatment: ____

Reason for treatment : ____

Is this visit due to a recent Workers' Compensation injury? ☐ YES ☐ NO Date: ____________________

Is this visit due to a recent automobile accident? ☐ YES ☐ NO Date: ___________________________

What other specialists have you seen for this condition? ____

____

Have you had radiographs of your spine within the last 10 years? ☐ YES ☐ NO

X-Ray Date: ________________ Facility: ____

X-Ray Date: ________________ Facility: ____

MRI Date: _________________ Facility: ____

CT Scan Date: _______________Facility: ____

What areas were x-rayed? ☐ Neck ☐ Mid Back ☐ Lower Back ☐ Additional Areas

____

____

****Patient Signature: X____ Date: _____________**

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Please list the symptoms and/or pain areas (for only those symptoms that apply to you) with **#10 being the most severe** and **#1 being the least severe**. Please include mild pain areas as well.

[This diagnosis section to be filled out by staff only.]

_____ No pain/symptoms. I want to get adjusted to stay well.

_____ Neck Pain – Approximate Date Pain Began: ______________________________ Diagnosis __________

______Upper back pain– Approximate Date Pain Began: __________________________ Diagnosis __________

_____ Shoulder joint pain– Approximate Date Pain Began: _______________________ Diagnosis __________

_____ Mid back pain – Approximate Date Pain Began: ___________________________ Diagnosis __________

_____ Headaches – Approximate Date Pain Began: ______________________________ Diagnosis __________

_____ Radiating pain down arm from neck – Approximate Date Pain Began: _________ Diagnosis _________

_____ Numbness/tingling describe area – Approximate Date Pain Began: ___________ Diagnosis __________

_____ Radiating pain down legs: describe area ____

Approximate Date Pain Began: ____ Diagnosis __________

_____ Low back pain – Approximate Date Pain Began: ___________________________ Diagnosis __________

_____ Hip pain – Approximate Date Pain Began: ________________________________ Diagnosis __________

_____ Knee pain – Approximate Date Pain Began: _______________________________ Diagnosis __________

_____ Asthma – Approximate Date Pain Began: _________________________________ Diagnosis __________

_____ Allergies – Approximate Date Pain Began: ________________________________ Diagnosis __________

_____ Muscle tenderness, describe area_______________________________________ Diagnosis __________

Approximate Date Pain Began: ____

_____ Tiredness/Low Energy– Approximate Date Pain Began: _____________________ Diagnosis __________

_____ Difficulty Walking – Approximate Date Pain Began: ________________________ Diagnosis __________

_____ Other radiating pain: Area From ________________ Area To _______________ Diagnosis __________

Approximate Date Pain Began: ____

_____ Other Complaints ____

____

****Patient Signature: X____ Date: _______________**

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FOR ALL PATIENTS WITH INSURANCE

If you need a receipt to submit to your insurance company, please let our office know. Initial Exam/Consultation are $45 and all adjustments are $45 payable at the time of the visit. We are considered an out of network provider for all insurance companies.

OFFICE POLICIES

Our mission is to provide high quality chiropractic care at an affordable cost. In order to accomplish this goal, we ask you for the courtesy of ***24 hours notice for cancellations and rescheduling*** **of appointments.** Cary Family Chiropractic, PLLC reserves the right to charge a $25 fee for appointments *cancelled with less than 24 hours notice*. All cancellations and appointment time changes must be **made via phone only at 919-650-1018, <u>not via text or email</u>**.

I have read the above polices and I accept the terms outlined. I understand and accept my financial responsibility to Cary Family Chiropractic, PLLC. We reserve the right to charge 1.5% interest per month on unpaid balances and 2.75% fee for credit card use. I understand that treatments in this office are for the purpose of removing nerve interference in my body by correcting vertebral misalignments (AKA subluxations). I understand that Cary Family Chiropractic, PLLC and Dr. Jill Goldberg does not treat or diagnose any medical conditions for the purpose of diagnosing the cause of pain. If I have concerns about a medical condition, I take responsibility for contacting my medical doctor for a diagnosis.

****Patient Signature: X____________________________________ Date:______________**

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AUTHORIZATION/HIPPA FORM POLICY

Effective date of policy: May 1, 2013

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations (TPO) and as otherwise required by law. Examples of some instances in which we are required to disclose your PHI include:
Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; correctional institutions; and Worker's Compensation.

Cary Family Chiropractic, PLLC will only use or disclose PHI, except as noted above, consistent with the terms of the authorization.

A patient may revoke his authorization to use or disclose PHI at any time but actions taken prior to the revocation are excluded. If authorization is a condition of obtaining insurance coverage, and the authorization is revoked, the insurer may contest a claim under the policy.

Authorizations must be properly executed by the patient or his personal representative. It should include, the date signed, specific PHI to be released or used, to whom this use or release relates, and an expiration date for the authorization.

Patient Signature: X__________________________________ Date: _____________

Patient Name Printed: ____

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ADDITIONAL INFORMATION

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