Your time is valuable. You can reduce your appointment time by completing the following forms and bringing them to your scheduled appointment. You do NOT need to send prior to your appointment.

Please fill out **completely**. If there is something that is not applicable to you, please note N/A or put a slash in the space.

Be sure to **sign and date all** highlighted areas.

If you have insurance (health, auto, etc.), please be sure to bring your card(s) with you.

You will also need to bring your driver's license AND either cash, check or credit card (Visa/MC/Discover)

If you have any questions prior to your appointment time, please call **704.544.1620 or email**

We look forward to the opportunity to help you.

*****There are reserved patient parking spaces when you pull in the parking garage**

We are located in the South Charlotte / Ballantyne Area
in the **Toringdon Business Park** at the intersection of Johnston Rd. and I-485
(BEHIND Earthfare **NOT** next to Red Robin Restaurant)

From Ballantyne
Take Johnston Rd north (toward I-485/Pineville)
Cross over I-485 and make 1st **RIGHT** on Toringdon Way (Red Robin on corner)
Make 2nd **RIGHT** (still Toringdon way)
#3520 straight ahead (connected to parking garage)

From Pineville / Hwy 51
Go south on Johnston Rd. (toward I-485 / Ballantyne)
Make **LEFT** on N. Community House Rd. (Ballantyne Jewelers on corner)
Make 2nd **RIGHT** on Toringdon Way (behind Earth Fare)
Make 2nd **LEFT** (still Toringdon Way)
#3520 straight ahead (connected to parking garage)

From 77 / I-485 East
Take exit 61, make **LEFT** off ramp onto Johnston Rd.
Go over I-485, make first **RIGHT** on Toringdon Way (Red Robin on corner)
Make 2nd **RIGHT** (still Toringdon Way)
#3520 straight ahead (connected to parking garage)

From Matthews / I-485 West
Take exit 61
Make **RIGHT** off ramp onto Johnston Rd.
Make 1st **RIGHT** on Toringdon Way (Red Robin on corner)
Make 2nd **RIGHT** (still Toringdon Way)
#3520 straight ahead (connected to parking garage)

The CHIROPRACTORS at *Toringdon* **WELCOME YOU!**

Patient Information

Name: _____
Last First MI Name you prefer to be called

Mailing Address: _____
Street City State Zip

Date of Birth: _____ Marital Status: ☐ Single ☐ Married ☐ Sep. ☐ Div ☐ Widowed

Phone #: (Home) _____ (Mobile) _____ (Work) _____

Can we contact you via text? ☐ Yes ☐ No

E-Mail Address: _____

Occupation: _____ Employer: _____ City/State: _____

Local Emergency contact: Name _____ Relation: _____

Phone #: (H) _____ (M) _____

How did you hear about our practice? ☐ Friend or Family Member's Name _____

☐ Other / please explain _____

Insurance Information

Do you have health insurance? ☐ No ☐ Yes Name of Carrier: _____

Is the insured ☐ Self ☐ Parent ☐ Spouse If spouse, indicate Employer Name: _____

Do you have secondary insurance? ☐ No ☐ Yes Name of Carrier: _____

I authorize, request, and assign my insurance company to pay directly to The Chiropractors at Toringdon the insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents. I also authorize the doctor to release any information necessary in order to process insurance claims. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____

(X) SIGNATURE **DATE**

Financial Information

I certify that I am financially responsible for this account whether or not paid by any insurance company or third party payer. If all charges are not paid in full within a timely fashion, collection action will be taken. I will be responsible for any costs involved with collection activity associated with this account, including, but not limited to collection agency or attorney fees.

_____

(X) SIGNATURE **DATE**

Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

☐ Neck Pain/Stiffness	☐ Pins/Needles in Arms	☐ Light Bothers Eyes	☐ Sudden Weight Loss	☐ Cold Sweats	☐ Chest Pain
☐ Back Pain/Stiffness	☐ Pins/Needles in Legs	☐ Depression	☐ Loss of Taste	☐ Cold Feet	☐ Fainting
☐ Arm/Hand Pain	☐ Sinus Problems	☐ Nervousness	☐ Loss of Smell	☐ Asthma	☐ Night Pain
☐ Leg/Knee Pain	☐ Sleeping Difficulties	☐ Tension	☐ Memory Loss/Confusion	☐ Fever/Chills	☐ Cough
☐ Headaches	☐ Bruising / Bleeding	☐ Nausea/Vomiting	☐ Constipation/Diarrhea	☐ Weakness	☐ Allergies
☐ Dizziness	☐ Ringing in Ears	☐ Stomach Problems	☐ Shortness of Breath	☐ Fatigue	
☐ Visual Changes	☐ Bowel/Bladder Changes	☐ Itching/Rash	☐ Swelling/Inflammation	☐ Jaw Problems	

Please check to indicate if you have ever had any of the following:

☐ Aids/HIV	☐ Cancer	☐ Hepatitis	☐ Osteoporosis	☐ Stroke
☐ Alcoholism	☐ Cataracts	☐ Hernia	☐ Pacemaker	☐ Suicide Attempt
☐ Allergy Shots	☐ Chemical Dependency	☐ Herniated Disc	☐ Parkinson's Disease	☐ Thyroid Problems
☐ Anemia	☐ Chicken Pox	☐ Herpes	☐ Pinched Nerve	☐ Tonsillitis
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Tuberculosis
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	☐ Polio	☐ Tumors/Growths
☐ Arthritis	☐ Epilepsy/Seizures	☐ Liver Disease	☐ Prostate Problems	☐ Typhoid Fever
☐ Asthma	☐ Fractures	☐ Measles	☐ Prosthesis	☐ Ulcers
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraines	☐ Psychiatric Care	☐ Vaginal Infections
☐ Breast Lump	☐ Goiter	☐ Miscarriage	☐ Rheumatoid Arthritis	☐ Venereal Disease
☐ Bronchitis	☐ Gonorrhea	☐ Mononucleosis	☐ Rheumatic Fever	☐ Whooping Cough
☐ Bulimia	☐ Gout	☐ Multiple Sclerosis	☐ Scarlet Fever	☐ Mumps
☐ Heart Disease	☐ Other _____			

Are you currently under drug and/or medical care? ☐ Yes ☐ No If yes, explain _____

Please list any medications you are currently taking (including over the counter medications): ☐ None

_____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Please list any surgeries and/or hospitalizations you have had (type & approx. date): ☐ None

_____

_____

Please list any allergies: ☐ None _____

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents, & siblings)

☐ Heart Disease _____ ☐ Diabetes _____ ☐ Other _____

☐ Cancer _____ ☐ Arthritis _____ _____

Do you exercise:	☐ Frequently	☐ Moderately	☐ Occasionally	☐ Never
Do you use Tobacco:	☐ Frequently	☐ Moderately	☐ Occasionally	☐ Never
Do you use Alcohol:	☐ Frequently	☐ Moderately	☐ Occasionally	☐ Never
Do your work activities mostly involve:	☐ Sitting	☐ Standing	☐ Light Labor	☐ Heavy Labor
Do you sleep on your:	☐ Back	☐ Side	☐ Stomach	
Do you use a cervical / neck pillow?	☐ Yes	☐ No		

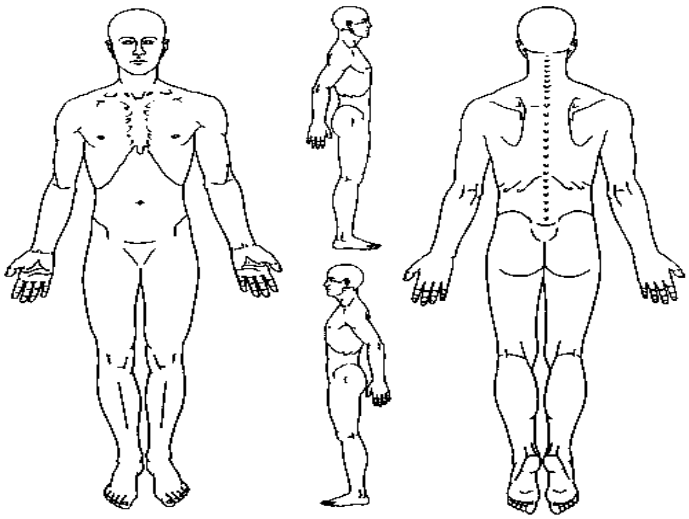
CONSENT TO CARE: I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I also **request and consent** to the performance of the appropriate examinations and treatment procedures, including but not limited to physical therapies, physical rehabilitation exercises, and /or manual therapy techniques. Though the forms of treatment stated above are usually beneficial and seldom cause problems, I understand and am informed that there are risks associated with all treatment. Risks may include, but are not limited to, sprains, dislocations, fractures, and disc injuries. The physician will not provide specific healthcare if he/she is aware that such care may be contra-indicated. I also understand that this healthcare facility will do its best to improve my health; however, it does not guarantee any results.

PRINTED NAME	(X) SIGNATURE	DATE

Chief Complaint

Reason(s) for visit: ☐ neck ☐ mid-back ☐ low back ☐ shoulder ☐ headaches ☐ general check-up ☐ other

Please mark all areas of pain or discomfort on the drawing below (circle or place an X):



Check all of the following that apply:

☐ tight	☐ stiff	☐ shooting
☐ ache	☐ dull	☐ burning
☐ numb	☐ sharp	☐ pins/needles
☐ throbbing	☐ tingling	

When did you first notice the pain / symptoms?_____

Did anything cause the pain / symptoms? _____

Is the pain: ☐ Constant ☐ Frequent ☐ Occasional

Is it getting progressively worse? ☐ No ☐ Yes

What makes it worse? _____

What makes it better? _____

Does it travel? ☐ No ☐ Yes If yes, where? ☐ Right Arm ☐ Left Arm ☐ Right Leg ☐ Left Leg

Rate the severity of your pain from **0-10** (10 being the worst possible pain) 1. ____ currently 2. ____ at it's worst

Do you experience the pain at a particular time of day? ☐ No ☐ Yes, when? _____

Do you experience night pain? ☐ No ☐ Yes, explain_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreational Activities

Painful Movements: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

What have you done and/or what medications have you taken (prescription or over the counter) to treat the pain before today?

_____

PRINTED NAME	(X) SIGNATURE	DATE

Consent for Use or Disclosure of Health Information

OUR PRIVACY PLEDGE

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your information.

- We may have to disclose your health information to another healthcare provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (154.520). We reserve the right to change our privacy practices as described in that notice. If we4 make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time: however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I also acknowledge that I have received a copy of this notice.

PRINTED NAME	(X) SIGNATURE	DATE