

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 do not print double sided!

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.

We are located in the South Charlotte / Ballantyne Area
in **Toringdon Circle** at intersection of Johnston Rd. and North Community House Rd.

Toringdon III Medical
12610 North Community House Rd., Ste 102
Charlotte, NC 28277

*** It is the building between Hickory Tavern and Pike Nursery and the entrance/parking lot are on the back side. We are the first suite on the left when you enter the building.

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 incurred 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:

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

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

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

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ | |

- | | | | | |
|---|-------------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| Do you exercise: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Moderately | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Do you use Tobacco: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Moderately | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Do you use Alcohol: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Moderately | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Do your work activities mostly involve: | <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Light Labor | <input type="checkbox"/> Heavy Labor |
| Do you sleep on your: | <input type="checkbox"/> Back | <input type="checkbox"/> Side | <input type="checkbox"/> Stomach | |
| Do you use a cervical / neck pillow? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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

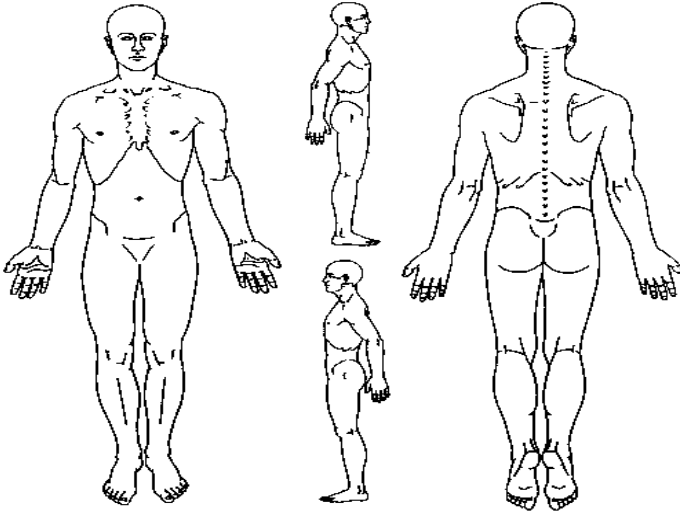
(X) SIGNATURE

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:

- | | | |
|------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> tight | <input type="checkbox"/> stiff | <input type="checkbox"/> shooting |
| <input type="checkbox"/> ache | <input type="checkbox"/> dull | <input type="checkbox"/> burning |
| <input type="checkbox"/> numb | <input type="checkbox"/> sharp | <input type="checkbox"/> pins/needles |
| <input type="checkbox"/> throbbing | <input type="checkbox"/> 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 we 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