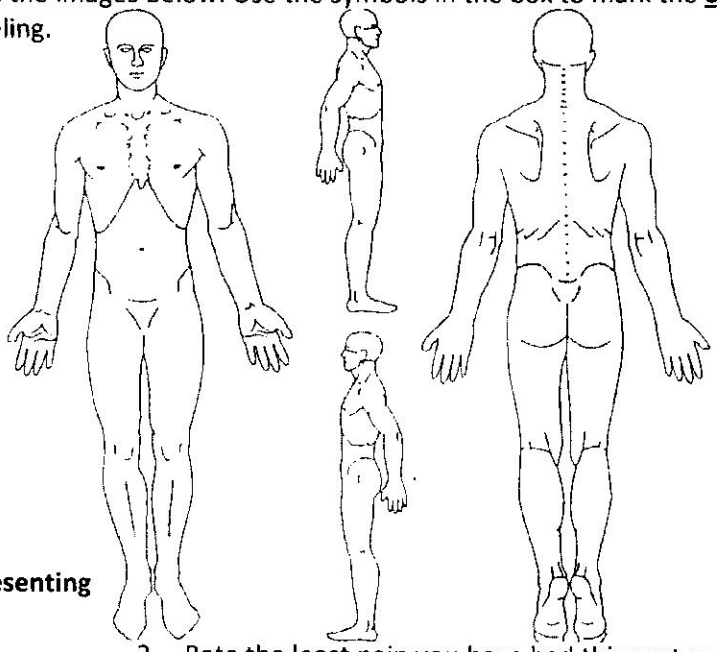
Albemarle Chiropractic

Patient's Name (Print):_____ DOB:_____ Date:_____

Please draw the location of your pain or discomfort on the images below. Use the symbols in the box to mark the **exact** location and the type of pain or sensations you are feeling.

>>>>>	Aching Pain
XXXXX	Burning Pain
= = = =	Numbness
OOOO	Pins & Needles
//////	Stabbing pain



On the scales below, please draw a vertical line representing the level of your pain or discomfort:

1. Rate the pain you have right **now**:

No Pain ——— Unbearable Pain

2. Rate the **least** pain you have had this past week:

No Pain ——— Unbearable Pain

3. Rate your **average** pain in the past week:

No Pain ——— Unbearable Pain

4. Rate the **most** pain you have had this past week:

No Pain ——— Unbearable Pain

For Office Use Only:

BP_____/_____ Pulse_____ Temp_____ Weight_____ Height_____

Gait_____ Ambulation_____

Major Complaint_____

History_____

Related Pain-Paresthesia_____

Aggravating Factors_____

Relief Factors_____

Cervical	Left	Right	Lumbar	Left	Right	Manual Test	Left	Right	Other
Cervical Flex			Rotation			Delts			
Rotation			Lat. Flex			Biceps			
Lat. Flexion			Flexion			Triceps			
Extension			Extension			Wrist Flex			
For. Compres.			For. Comp.			Wrist Ext			
Georges			Kemps			Hams			
Spurlings			SLR			Psoas Maj.			
Carotid			Valsalva			Quads			
			Torque Test			Great Toe Ext			
			Hip Ext			Great Toe Flex			
			Hip Int						
			Abdominal B.						

Painful Hypertonic Muscles _____

Joint Fixations _____

Deep Tendon Reflexes				Dermatome				
	C-5				C-5		L-3	
	C-6				C-6		L-4	
	C-7				C-7		L-5	
	L-4		S-1		C-8		S-1	

ALBEMARLE CHIROPRACTIC OFFICES HEALTH UPDATE FORM

Name of Patient _____DOB_____Age_____

Address_____

Cell #_____ Work #_____Home #_____

To ensure our information is correct and up to date, please take a minute to answer the following questions:

Have you had any trauma since your last visit? IE; falls, auto accident, ect. Yes_____No_____

If yes, please describe and give the approximate date _____

Any serious illnesses or hospitalizations? Yes_____No _____If yes, please describe and give a date.

_____

Do you feel your problem today is in the same area that we have treated before? Yes _____No_____

I yes, did you previously discontinue the care recommended by your doctor? Yes_____No_____

Describe the condition you are here for today _____

_____

How did this most recent condition start? Please describe_____

_____

When did this condition start? Date:_____Was this work related? Yes_____No_____

Have you lost any time at work due to this problem? Yes_____No_____

List all medications you are presently taking_____

_____

Are you pregnant at this time? Yes_____No_____

Has your insurance information changed? Yes_____No_____ If so, please give your card to the front desk. We will need to make a copy.

INSURANCE VERIFICATION INFORMATION

Name of insurance company _____

Subscriber Name (If different from patient)_____

Subscribers Relationship to Patient_____Subscriber Date of Birth_____

Patient ID (Subscriber) #_____Group #_____

Do you prefer to pay by Cash_____Credit/Debit_____Check_____

Patient Signature _____Date_____

Albemarle Chiropractic

Functional Rating Index

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.

For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot Work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of Pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased Pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ _____ **Total Score** _____

Printed DOB

_____ _____

Signature Date

ALBEMARLE CHIROPRACTIC OFFICES PA
1745B City Center Boulevard
Elizabeth City, NC 27909
252-338-3206

(Consent to use PHI) Notice of Privacy Practices- Acknowledgement & Consent

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 Albemarle Chiropractic Offices 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 r 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 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 of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

We do not release any protected health information outside Albemarle Chiropractic office without your written consent.

By my signature below I give my permission to use and disclose my protected health information in Albemarle Chiropractic's office only.

_____ _____

Patient of Legally Authorized Individual Signature | Date

_____ _____

Print Patient's Full Name | Time

_____ _____

Witness Signature | Date

ALBEMARLE CHIROPRACTIC OFFICE
INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Medical doctors, chiropractor doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain your informed consent before starting treatment.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
Fractures: I understand that in isolated cases, underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc or other abnormality is detected, this office will proceed with extra caution.
Stroke: although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage, including stroke, is reported to occur once in one million-once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures, including decreased pain, improved mobility and function and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of the doctors choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternative have been explained to me, including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery. **Medication** can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence and may have to be continued indefinitely. Some medications may involve serious risks. It has been explained to me that **rest/exercise** is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of, ice, heat or other home therapy. Prolonged bed rest contributes, to weakened bones and joint stiffness. Exercises are of limited value, but are not corrective of injured nerve and joint tissues. **Surgery** may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery. I understand the potential risks of **nontreatment** may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation and worsening pathology. The aforementioned may complicate treatment, making future recovery and rehabilitation more difficult and lengthy.

I have read the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction **PRIOR TO MY SIGNING THIS CONSENT FORM**. I have made my decision voluntarily and freely. To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Patient Signature_____Date_____

Authorized provider representative signature _____

ALBEMARLE CHIROPRACTIC OFFICES PA
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252-338-3206

FINANCIAL POLICY

Welcome to Albemarle Chiropractic Offices. Please read the information below. Once you have read the information, please sign the form and return to the front desk. Please let us know if you have any questions. Thank you.

Payment is required at each visit. If you are unable to make your copay/maintenance payment or coinsurance, you may need to reschedule your visit.

It is your responsibility to know your chiropractic insurance benefits. Keep in mind, they may differ from your medical doctor benefits. We will try and verify your chiropractic benefits. Please note: the benefits quoted are not a guarantee of payment. A decision is made by your insurance company when each claim is received. You are responsible for any services your insurance company does not pay.

****The doctors work hard to see each patient in a timely fashion. Therefore, it is expected that our patients arrive on time for each appointment. Patients who arrive late may need to reschedule.****

At least 24 hours' notice is required If you find you are unable to keep your appointment. This allows us time to place another patient in that time slot. A fee may be charged if less than 24 hours' notice is given.

THERE IS A CASH FEE OF $50.00 FOR MISSED APPOINTMENTS, WITHOUT PRIOR NOTIFICATION.

I HAVE READ AND AGREE TO THE TERMS ABOVE

Patient name (print)_____

Patient Signature_____ **Date**_____

Staff/witness signature_____ **Date**_____