HIGHLAND CREEK CHIROPRACTIC AND ACUPUNCTURE
10030 EDISON SQUARE DR. NW
CONCORD, NC 28027

PATIENT HISTORY

Patient Name _________________________________Date of Birth____/______/______ Age_______
Home Address _______________________________ City _______________State _____Zip_________
Email ____
Home Phone ________________Work Phone ___________________Cell Phone__________________
SS# __________-__________-_________ Sex □ Male □ Female Marital Status_____________
Employer____ Job Description________________________
Emergency Contact _________________________________Relationship _________________________
Phone Number______________________________________
How did you hear about our office? □ Patient Referral □ Internet □ Drive by
What is the reason for this visit? ____
Is this related to an auto accident? □ Yes □ No Date of the Accident: ____/_____/______
If 'YES' how did the accident occur?____
Have you seen any other physicians for this condition? □ Yes □ No
If 'YES' who? ___________________________Type of Treatment: ____________________________
Have you been treated by a doctor or health care professional within the last year? □ Yes □ No
If 'YES', for what conditions?
____
Have you been under Chiropractic Care before? □ Yes □ No
Where____
Who is responsible for payment? □ Self □ Spouse □ Health Ins. □ Auto Ins. □ Workman's Comp

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INSURANCE INFORMATION

Insurance Provider _______________________________Phone Number _______________________________

Policy/Subscriber ID_______________________________________ Group # ____________________________

AUTO INSURANCE INFORMATION (If applicable)

Liability Insurance __________________________________Phone Number _______________________________

Claim # ____

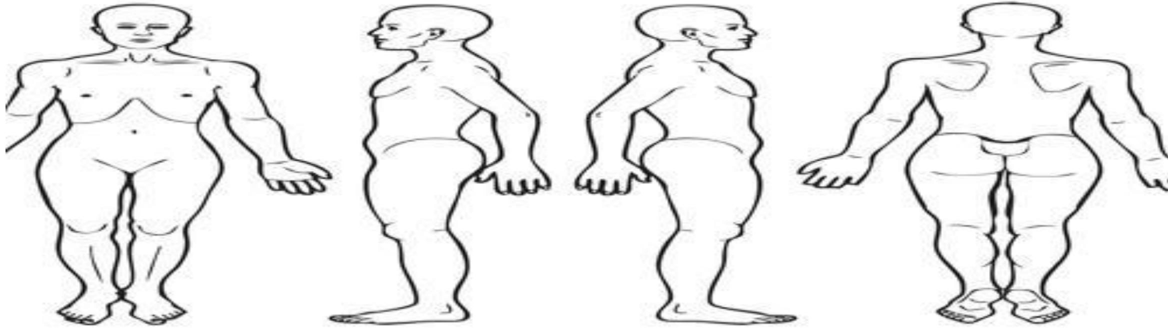
I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN AGREEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THIS CHIROPRACTIC OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY THIS CHIROPRACTIC OFFICE WILL BE CREDITED TO MY ACCOUN UPON RECEIPT. I ALSO GIVE THIS OFFICE POWER OF ATTORNEY TO ENDORSE CHECKS MADE OUT TO ME, TO BE CREDITED TO MY ACCOUNT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

Patient/Guardian Signature: ____ **Date**: ___________________

PATIENT INTAKE FORM

Patient Name_____________________________________ **Date**________________________

1. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation
2. Indicate on the drawing below where you have pain/symptoms



3. **How often do you experience your symptoms?**
   ☐ Constantly (76-100%) ☐ Occasionally (26-50%)
   ☐ Frequently (51-75%) ☐ Intermittently (1-25%)

4. **How would you describe the type of pain?**
   ☐ Sharp ☐Numb
   ☐ Dull ☐ Tingly
   ☐ Diffuse ☐ Sharp with motion
   ☐ Achy ☐ Shooting with motion
   ☐ Burning ☐ Stabbing with motion
   ☐ Shooting ☐ Electric like with motion
   ☐ Stiff ☐ Other ____________________________

5. **How are you symptoms changing with time?**
   ☐ Getting Worse ☐ Staying the same ☐ Getting better
6. **Using a scale from 0-10 (10 being the worst), how would you rate your problem?**
   0 1 2 3 4 5 6 7 8 9 10 (please circle)
7. **How much has the problem interfered with your work?**
   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
8. **How much has the problem interfered with your social activities?**
   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
9. **Who else have you seen for your problem?**
   ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
   ☐ ER physician ☐ Orthopedist ☐ Other_______________
   ☐ Massage Therapist ☐ Physical Therapist ☐ No one
10. **How long have you had this problem?**_______________________________________
11. **How do you think your problem began?**
    ____
12. **Do you consider this problem to be severe?**
    ☐ Yes ☐ Yes, at times ☐ No
13. **What aggravates your problem?**
    ____
14. **What alleviates your problem?**
    ____
15. **What concerns you the most about your problem; what does it prevent you from doing?**
    ____
16. **What is your**: **Height**________ **Weight**___________ **Date of Birth**____/_____/______

17. Occupation:

Trader	Professional/Executive	White Collar	Tradesperson	Retired
Laborer	Homemaker	Truck Driver	Student	Unemployed

Other:____

18. In general, how do you rate your overall health?

Excellent	Very Good	Good	Fair	Poor

19. What kind of exercise do you perform?

Strenuous	Moderate	Light	None

20. Do you have an immediate family member with any of the following?

Rheumatoid Arthritis	Heart Problems	Diabetes
Cancer	Lupus	ALS

Other:____

21. Please check all that apply to you in the appropriate column:

Past	Present	Past	Present	Past	Present
☐	☐ Headaches	☐	☐ High Blood Pressure	☐	☐ Diabetes
☐	☐ Neck Pain	☐	☐ Heart Attack	☐	☐ Excessive Thirst
☐	☐ Upper Back Pain	☐	☐ Chest Pains	☐	☐ Frequent Urination
☐	☐ Mid Back Pain	☐	☐ Stroke	☐	☐ Smoking/Tobacco Use
☐	☐ Low Back Pain	☐	☐ Angina	☐	☐ Drug/Alcohol Dependence
☐	☐ Shoulder Pain	☐	☐ Kidney Stones	☐	☐ Allergies
☐	☐ Elbow/Upper Arm Pain	☐	☐ Kidney Disorders	☐	☐ Depression
☐	☐ Wrist Pain	☐	☐ Bladder Infection	☐	☐ Systemic Lupus
☐	☐ Hand Pain	☐	☐ Painful Urination	☐	☐ Epilepsy
☐	☐ Hip Pain	☐	☐ Loss of Bladder Control	☐	☐ Dermatitis/Eczema/Rash
☐	☐ Upper Leg Pain	☐	☐ Prostate Problems	☐	☐ HIV/AIDS
☐	☐ Knee Pain	☐	☐ Abnormal Weight Gain/Loss		
☐	☐ Ankle/Foot Pain	☐	☐ Loss of Appetite	**For Females Only**	
☐	☐ Jaw Pain	☐	☐ Abdominal Pain	☐	☐ Birth Control Pills
☐	☐ Joint Pain/Stiffness	☐	☐ Ulcer	☐	☐ Hormonal Replacement
☐	☐ Arthritis	☐	☐ Hepatitis	☐	☐ Pregnancy
☐	☐ Rheumatoid Arthritis	☐	☐ Liver/Gallbladder Disorder		
☐	☐ Cancer	☐	☐ General Fatigue		
☐	☐ Tumor	☐	☐ Muscular Incoordination		
☐	☐ Asthma	☐	☐ Visual Disturbances		
☐	☐ Chronic Sinusitis	☐	☐ Dizziness		
☐	☐ Other:____				

22. Please list all prescription medications you are currently taking:

____

23. Please list all supplements you are currently taking:

____

24. Please list all surgical procedures you have had:

____

25. What do you do at work?

Sits most of the day	Sits about half the day	Sits a little of the day
Stands most of the day	Stands about half the day	Stands a little of the day
Computer most of the day	Computer about half the day	Computer a little of the day
On the phone most of the day	On the phone about half the day	On the phone a little of the day
Drives most of the day	Drives about half the day	Drives a little of the day
Performs manual labor most of the day	Reads a lot about half the day	Travels frequently a little of the day
None		

Other:____

26. What do you do outside of work?

Aerobics	Skiing	Basketball	Soccer	Baseball	Softball
Bicycling	Swimming	Football	Tennis	Golf	Triathlons
Hiking	Volleyball	Ice Hockey	Walking	Inline Skating	Weight Lifting
Jogging	Working Out	Martial Arts	Yoga	Rock Climbing	

Other:____

27. Have you had any hospitalization?

Yes	No	Previously Mentioned

28. Have you had any significant past trauma?

Yes	No	Previously Mentioned

If yes, please list:____

29. Is there anything else you think I should know?

Yes	No	Previously Mentioned

If yes, please list:____

Notice of Privacy Policy for Patient's Protected Health Information

THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW CAREFULLY

- This office abides by the terms described in this policy
- This office uses and discloses your Protected Health Care Information for the following reasons:
    - To share with other treating health care providers regarding your health care
    - To submit to health insurance, Worker's Compensation or other insurance companies to verify that your Chiropractic services have been rendered
    - To determine patients benefits in a health care plan
    - As required by State and Federal Public Health Law
    - To assist in overcoming a language barrier when caring for patient
    - In emergency situations
    - In abuse, neglect or domestic violence situations
    - To provide appointment reminders to household members or answering machines
    - To send emails pertaining to patient care and for appointment reminders
    - To send text messages for appointment reminders
    - When required by law enforcement authorities

Any other uses or disclosers will only be made with your specific written, prior authorization. Disclosures of protected information are limited to the minimum necessary for the purpose of disclosure.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom
- Speak to our Privacy Officer, who is Dr. Michael J. Landers, and can be reached at 704-948-6453, regarding privacy issues
- Inspect, copy, and amend your Protected Health Information, as allowed by law
- Obtain an accounting of disclosures of your Protected Health Information
- To render a complaint to our Privacy Officer or to the Secretary of Health and Human Services

You may request changes to your records. Our practice has the right to accept or deny your request.

This office reserves the right to change the terms of this notice and to make new notice provisions for all Protected Health Information that it maintains. Patients may also get an updated copy upon request at any time, by asking the staff.

Patient Name:____

Patient/GuardianSignature:____**Date:**____________

CONSENT TO CHIROPRACTIC AND ACUPUNCTURE TREATMENT

To the patient,

Under North Carolina Law, your Chiropractic Physician has a duty to explain the treatment being recommended, to inform you of the usual risks associated with treatment, to explain other treatment options and to answer any questions you may have regarding treatment. You may have been given reading material pertaining to these topics, but your Doctor is also obligated to discuss them with you in person. Do not sign this form until you are satisfied that you have received sufficient information to enable you to give your informed consent to treatment.

Note: If the patient is a minor or legally incompetent adult, consent should be given by the patient's parent or legal guardian.

The recommended Chiropractic/Acupuncture treatment plan has been explained to me, along with the risks associated with Chiropractic/ Acupuncture treatment and other treatment options. I have discussed these matters with my attending Chiropractic Physician at Highland Creek Chiropractic & Acupuncture, PLLC, to my satisfaction. No guarantees have been made to me regarding treatment outcomes. I have weighed the risks involved and have decided that it is in my best interest to undergo the treatment recommended. I hereby give my consent to Chiropractic and/or Acupuncture treatments at Highland Creek Chiropractic & Acupuncture, PLLC, by who may treat me now or in the future. This consent will include those employed by, working for, or associated with Highland Creek Chiropractic & Acupuncture.

Patient's Name: ____

Patient's Signature:____ Date: ____________

If the patient is a minor or legally incompetent adult, complete this section:

Patient's Name:____

Patient's Age: __________ Date of Birth:_____/____/_____

Person authorized to sign for this patient (print):_______________________________________

Relationship to Patient: __________________________________

Signature of Authorized Person: ___________________________________Date:____________

I have personally discussed informed consent with this patient and they have given their verbal consent, prior to treatment

Doctor's Signature:____Date:_______________

PATIENT CONSENT TO X-RAY

I authorize the performance of a diagnostic Radiology examination of myself, which Highland Creek Chiropractic & Acupuncture may consider necessary or advisable in the course of my examination and treatment.

Signed: ____ Date:__________

If Patient is a Minor:

I am the parent or legal representative of ___________________________________ who is a minor. I authorize the performance of a diagnostic radiology examination of this minor which Highland Creek Chiropractic & Acupuncture may consider necessary or advisable.

Signed: ____ Date __________

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am not pregnant, and Highland Creek Chiropractic & Acupuncture has my permission to perform a diagnostic Radiology Examination. I have been advised that certain Radiology Examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed: ____ Date: _________

CANCELLATION POLICY

In order to serve our patients better, we have instituted a cancellation policy. If you cannot make it to your appointment, please contact us 24 hours in advance to cancel your appointment. If you do not cancel 24 hours in advance, you may be subject to a $25.00 prepayment before scheduling your next appointment.

******** IMPORTANT ********

As the patient, it is your responsibility to keep all scheduled appointments. If you do not keep a scheduled appointment, we will attempt to contact you to reschedule your missed appointment(s). If you do not attempt to contact this office within one week of your missed appointment, you were thereby discharging yourself from treatment at this facility. Further, if you discharge yourself, from this facility, it is your responsibility to seek treatment from another physician regarding any issue for which you were seeking care here, as well as any other issues that may have arisen since receiving treatment here.

We will be most accommodating with regard to your schedule and your treatment here. If you decide to discharge yourself from this facility, we will assist you, at your request, in locating other providers and treatment options.

Print Name: ____ Date:_____________

Signature: ____ Date:_____________