

Patient Information*

Thank you for choosing our practice for your chiropractic needs. If you have any questions, do not hesitate to ask for assistance. We will be happy to help!

Today's Date: _____ Sex: Male Female
Name: _____
Address: _____ Birthdate: _____
City, State, Zip: _____ Home phone: _____
Where do you prefer to receive calls? _____ Work Phone: _____
Your employer: _____ Cell Phone: _____
Occupation: _____ Workplace: _____
Email address: _____
Preference of contact: Email Text, Cell phone carrier Home Phone
Are you: Minor Single Married Divorced Widowed Separated
Spouse's and children's names: _____
Person to contact in case of emergency: _____ Phone: _____
Primary Care MD: _____ Phone: _____
Whom may we thank for referring you to us? _____

** If this is a workman's compensation case or a motor vehicle accident, please stop and inform the receptionist.*

Responsible Party

Name of person responsible for this account: _____
Address: _____ Phone: _____
City, State, Zip: _____ Work Phone: _____
Relationship to patient: _____
Method of payment for today's charges: Cash Check Charge

Notice: All first visit charges are payable when services are rendered. The fee paid for the x-rays is for analysis only. The film itself is the property of this office; however, the films may be checked out by the patient.

This office will *verify* insurance coverage for you. This is done as a courtesy for you, so please make sure we have your insurance card.

Chief Complaint

Rank your overall Health (Scale 1-10, 10 being perfect) _____
Do you think you have a simple muscle problem or a more serious nerve, disc or arthritis issue? _____

Are you looking for temporary relief or corrective care?

Reasons for visit: Wellness Care Nutrition Exercise Posture Neck pain Headaches
 Mid-back Low back TMJ Wrist Leg Shoulder Knee
 Ankle Elbow Foot Other _____

Primary Complaint is:

Please complete the following questions regarding your **PRIMARY COMPLAINT**.

How did your main problem appear? Gradually Suddenly Accident/trauma Do not know

Is your problem present...? 100% 75% 50% 25% Less than 25% of the time

Is your problem getting worse...? Better Worse Staying the same

Is your problem worse...? Morning Day Evening Night

Does your problem keep you from...? Working Sleeping Your daily routine

Indicate the severity of your main problem... 1-10 (0 No Pain and 10 Extreme Pain): _____

Difficult activities: Sitting Laying down Standing Walking Bending Other

Type of pain: Throbbing Dull Sharp Numbness Aching Shooting

Burning Tingling Cramping Swelling Other _____

Have you seen another health professional for your problem? No Chiropractor Medical Other

Name and address of other doctor(s) who have treated you for your condition: _____

Health History

Please check all that apply to you.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Easily bruised | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Shaking |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Numbness | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Foot Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Cardiac problems |
| <input type="checkbox"/> Abdominal Gas | <input type="checkbox"/> Skin eruptions (redness) | <input type="checkbox"/> Irritability | <input type="checkbox"/> Blood circulation problems |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Dizziness/ vertigo | <input type="checkbox"/> Hereditary diseases | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Back pain | <input type="checkbox"/> Eye problems |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Cold extremities | <input type="checkbox"/> Headaches | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Edema (swelling) | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Fractures | <input type="checkbox"/> Operations/ Surgery | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Shivers | <input type="checkbox"/> Loss or gain of weight | <input type="checkbox"/> Hormonal problems |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Psychological problems |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Other: _____ | | | |

Date of last exam: _____

Women: Are you pregnant? Yes No Are you nursing? Yes No Painful Menstruation
Women: No Menstruation Abdominal Cramps Abundant Menstrual Flow Menopause symptoms

Please list any surgeries and the dates they occurred:

Please list all medications you are currently taking: No Anti-inflammatory Pain Killers
 Muscular Relaxants Hormones High Blood Pressure Diabetes 'The Pill'
 Non-Prescribed medicines Other _____

Please list all known allergies: _____

Daily Habits

Do you exercise? No Yes
What do your daily work habits include? Sitting Standing Moving
 Heavy Labor Driving Computer work Other: _____
What kind of vitamins do you currently take? _____
What kind of other supplements do you take? _____
Do you smoke? Yes No How much per day? _____
How much alcohol do you consume on a weekly basis? _____
How much caffeine do you consume on a daily basis? _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such chiropractic care to third party payers and/or health practitioners. Providing my insurance is accepted, I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand, provided my insurance is accepted, that the carrier may pay less than the actual bill for the services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Signature of patient (or parent if a minor)

Date

PATIENT CONSENT

I, _____, hereby consent to Team Chiropractic permission to call my home, cell, and work number for appointment reminders and routine office needs regarding my account.

I hereby consent for Team Chiropractic to leave any messages for appointments, changes in schedule, and routine office needs with the following family members:

_____	Relation: _____
_____	Relation: _____
_____	Relation: _____
_____	Relation: _____
_____	Relation: _____

I hereby revoke any information to be given to the following family members regarding any routine office needs here at Team Chiropractic:

_____	Relation: _____
_____	Relation: _____
_____	Relation: _____
_____	Relation: _____
_____	Relation: _____

Due to the privacy act created by the Centers for Medicare and Medicaid, this office is required to have your signature allowing us to treat you. If you would like to have the details pertaining to the Health Information Portability and Accountability Act (HIPAA), please ask the receptionist for the Notice of Privacy Practices.

“I have read and understand the notice of privacy practices and hereby give my consent to this office to attend to me according to the usual and customary practices contained therein.”

Patient Name, printed

Patient Signature

Date

ORIENTATION & INFORMED CONSENT TO CHIROPRACTIC TREATMENT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment. **Chiropractic has only one goal: to eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom.** We do not offer to diagnose or treat any disease or condition other than vertebral subluxation.

Allow us to introduce some terms you need to be familiar with as you receive your chiropractic care:

- **Adjustment:** the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine and extremities. **Dr. Lawrence D. Dodd and his associates** will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop." Cold packs, diet, nutritional supplementation, exercises, traction or any other treatments may also be used.
- **Health:** a state of optimal physical, mental, and social well being, not merely the absence of disease or infirmity.
- **Vertebral Subluxation:** a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation or exercises. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. Cerebrovascular injury or stroke leading to death could occur upon severe injury to arteries of the neck. Nutritional supplementation we recommend may cause energy or chemical imbalances causing injury or death.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare," about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and may be even further reduced by screening procedures.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I, _____, have read and fully understand the above statements. I have also had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment plan, and herby give my full consent for chiropractic care.

Signature

Date

I hereby grant permission to Team Chiropractic to perform any necessary tests on my minor child, and to render care for said child. I acknowledge that I am the parent or legal guardian of the child listed on this form.

Signature of Parent or Legal guardian

Date

An Informed Consent to X-Ray

Team Chiropractic & Sports Medicine

309 W. Millbrook Dr. #199

Raleigh, NC 27609.

(919) 788-8881

I _____ hereby allow the doctors, assistants, or designated staff of *Team Chiropractic and Sports Medicine* to perform any x-ray procedures necessary. I understand that these procedures are useful in helping to determine the cause of my problem. They may also be used for subsequent re-evaluations to determine my progress throughout my treatment program.

My understanding is that the actual x-ray film is the property of *Team Chiropractic and Sports Medicine*; however, the information on the film is mine. I am able to obtain a copy of these films at an additional charge to pay for the physical film itself.

Team Chiropractic and Sports Medicine does allow a patient to borrow their x-ray films for a maximum of thirty (30) days in order to coordinate care with other health care professionals. This requires a signed release from the health professional and has a strict 30 day return policy. *Team Chiropractic and Sports Medicine* is held legally liable to have original copies of all x-rays taken at this clinic for a minimum of seven (7) years.

I understand that if I am pregnant and have X-rays taken which expose my lower torso to radiation there is a risk that my fetus may be injured.

I have been advised that the 10 days following the onset of a menstrual period are generally considered to be safe for X-ray examinations.

With those factors in mind, I am advising my doctor that:

	Yes	No	Don't Know
I am pregnant	___	___	___
I could be pregnant	___	___	___
I am late with my menstrual period	___	___	___
I am taking oral contraceptives	___	___	___
I have an IUD	___	___	___
I have had a tubal ligation	___	___	___
I have had a hysterectomy	___	___	___
I have irregular menstrual periods	___	___	___
My last menstrual period began on: _____			

An X-Ray may be performed on me with my consent.

Patient: Signature _____ Date _____

Print _____

Witness: Signature _____ Date _____

Print _____