

Carolina Family Chiropractic, P.A.

Date

Patient Data

Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address Line 1 _____

Mailing Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone (____) _____ - _____ **Work Phone** (____) _____ - _____

Cell Phone (____) _____ - _____ **Email** _____

Date of Birth ____/____/____ **Sex:** Male Female

Social Security Number: _____ - _____ - _____ **Marital Status:** Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other _____

Spouse Data

First Name _____ **Middle Initial** ____ **Last Name** _____

Home Phone (____) _____ - _____ **Work Phone** (____) _____ - _____

Employer Data

Name _____

Your Occupation _____ **Your Job Description** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Emergency Contact

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (____) _____ - _____ **Cell Phone** (____) _____ - _____

Carolina Family Chiropractic, P.A.

Patient Name _____ **Date** _____

Who referred you to our office? _____

Have you received previous Chiropractic care? ____ Yes ____ No **When?** _____

Medical Conditions: (Check all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____			

Surgeries: (Check all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Other _____			

Allergies: (Check all that apply to you)

Eggs	Fish and Shellfish	Milk or Lactose	Peanuts
Soy	Sulfites	Wheat/Glutens	Other _____

Social History: (Check all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Chew Tobacco:	occasional	often	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Wear Seat Belts:	occasional	always	never
Other _____			

Family History: (Check all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling
Other _____		

Do You Use:

Supplements? ____ Yes ____ No
Herbs? ____ Yes ____ No
Essential Oils ____ Yes ____ No
If so, List _____

If No, Are you interested? ____ Yes ____ No

Occupational Activities: (Check one that best describes your job description)

Administration	Business Owner	Clerical/Secretary	Computer User
Heavy Equipment operator	Daycare/Childcare	Construction	Health Care
Food Service Industry	Medium Manual Labor	Manufacturing	Home Services
Heavy Manual Labor	Light Manual Labor	Executive/Legal	Housekeeper
Other _____			

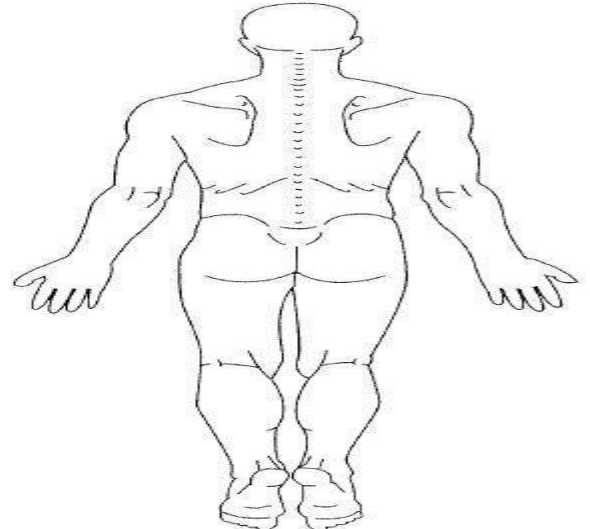
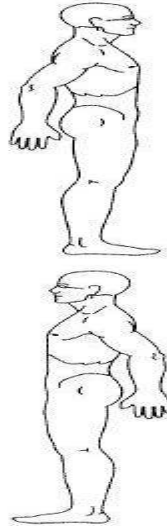
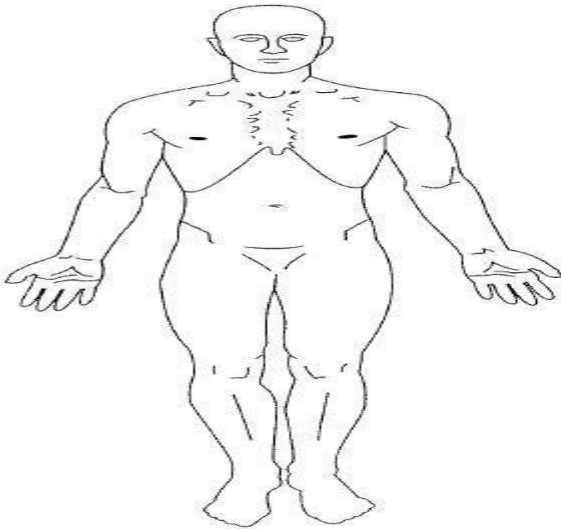
Carolina Family Chiropractic, P.A.

Patient Name _____ **Date** _____

Are you pregnant? Yes _____ No _____ N/A _____ Expected Due Date _____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Other symptoms:

- | | | |
|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Fever | <input type="checkbox"/> Buzzing in Ears |

Describe your symptoms in order of severity, with worse symptom being #1: _____

When did your symptoms begin? Month _____ Day _____ Year _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other _____

How did your symptoms begin? _____

How often do you experience your symptoms?

Constantly
(76-100% of the day)

Frequently
(51-75% of the day)

Occasionally
(26-50% of the day)

Intermittently
(0-25% of the day)

Carolina Family Chiropractic, P.A.

Patient Name _____ **Date** _____

Please List Current Medications: _____

Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Spouse Worker's Comp
Auto Insur. Medicare Medicaid Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Primary Care Physician _____

I do hereby authorize Carolina Family Chiropractic, P.A. (Dr. Richard M Kuhns, III) to furnish my Insurance Co electronically a full report of physical examination, diagnosis, treatment, prognosis, etc. of myself in regard to my injury, if requested by the Insurance Company.

I hereby authorize and direct payment directly to said doctor such sums as may be due and owing him for chiropractic services rendered me. I understand I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me. This agreement is made solely for said doctor's additional protection and in consideration of awaiting payment.

I have read and agree to be bound by the terms of this agreement and this assignment of benefits. I have also been advised that if my insurance co does not cooperated in protecting said doctors' interest, he will not await payment but may declare the entire balance due and payable; these assigned proceeds shall not exceed amounts due and payable to said doctor for services rendered.

Patient Signature _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date: ____/____/____ Time: _____ am / pm

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____

Date _____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____

Date _____