



Patient Information

Date: _____

Patient Name: _____
Last Name First Name Middle Initial

Date of Birth: _____ SS#/Patient ID # _____

Address: _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ Cell Phone (____) _____

Emergency Contact:

Name _____ Relationship _____

Home Phone (____) _____ Cell Phone (____) _____

Sex: Male Female

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Referred By: _____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ____

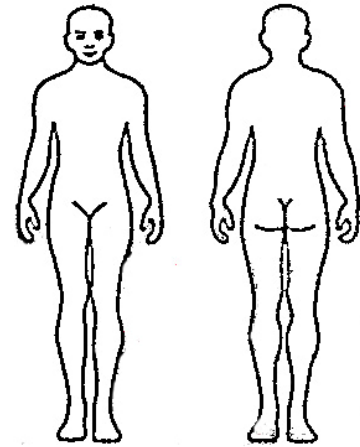
How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your __Work __Sleep __Daily Routine __Recreation

Activities or movements that are painful to perform
__Sitting __Standing __Walking __Bending __Lying Down

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
(circle) Burning Tingling Cramps Stiffness Swelling Other



Insurance Information

I certify that I, and/or my dependent (s) have insurance coverage with _____ and assign directly to Palmetto Chiropractic Neck and Back Center all insurance benefits, if an, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Palmetto Chiropractic Neck and Back Center may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the sole purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian, or Personal Representative Relationship Date



Health History

What treatment have you already received for your condition? Medications Surgery Physical Therapy
Chiropractic Services None Other_____

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

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____
Spinal Exam_____ Chest X-Ray_____ Urine Test_____
Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

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

- | | | | |
|---------------------|------------------|----------------------|-----------------------|
| AIDS/HIV | Diabetes | Measles | Rheumatic Fever |
| Alcoholism | Emphysema | Migraine Headaches | Scarlet Fever |
| Allergy Shots | Epilepsy | Miscarriage | Stroke |
| Anemia | Fractures | Mononucleosis | Suicide Attempt |
| Anorexia | Glaucoma | Multiple Sclerosis | Thyroid Problems |
| Appendicitis | Goiter | Mumps | Tonsillitis |
| Arthritis | Gonorrhea | Osteoporosis | Tuberculosis |
| Asthma | Gout | Pacemaker | Tumors, Growths |
| Bleeding Disorders | Heart Disease | Parkinson's Disease | Typhoid Fever |
| Breast Lump | Hepatitis | Pinched Nerve | Ulcers |
| Bronchitis | Hernia | Pneumonia | Vaginal Infections |
| Bulimia | Herniated Disk | Polio | Venereal Disease |
| Cancer | Herpes | Prostate Problem | Whooping Cough |
| Cataracts | High Cholesterol | Prosthesis | Other, please explain |
| Chemical Dependency | Kidney Disease | Psychiatric Care | _____ |
| Chicken Pox | Liver Disease | Rheumatoid Arthritis | _____ |

Exercise	Work Activity	Habits	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	Packs/Day_____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	Drinks/Week_____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine Drinks	Cups/Day_____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress Level	Reason_____

Are you pregnant? Yes No If Yes, Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications	Allergies	Vitamins/Herbs/Minerals

Pharmacy Name: _____ Phone:(____)_____



QUANTITATIVE HEADACHE INDEX

This questionnaire has been designed to give the doctor information as to how headaches have affected your ability to manage everyday life. Please answer every section and mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section relates to you, but please mark the box which most describes your problem.

1.) Current difficulties

- I have no headache problems at this moment.
- I have mild headache problems at this moment.
- I have moderate headache problems at this moment.
- My headache problems are fairly severe at this moment.
- My headache problems are severe at this moment.
- My headache problems are very severe at this moment.

2.) How many times have you ever been hospitalized for headaches? (Include emergency room visits.)

- Never
- One time
- Two times
- Three times
- Four times
- Five or more times

3.) When was the last time you had a severe flare-up or needed urgent medical treatment for your headache?

- Never
- More than twelve months ago
- Within the last twelve months
- Within the last six months
- Within the last month
- Within the last week

4.) How often do headaches awaken you at night?

- Never
- Less than once a week
- Once or twice a week
- Three of four times a week
- Five of six times a week
- Every night

5.) My headache lasts

- Less than one hour
- Less than six hours
- One day
- One day and one night
- Multiple days

6.) I currently have headaches

- Never
- Occasional (once a month)
- Sometimes (one a week)
- Frequently (one a day)
- Always (all day)
- Multiple days at a time

7.) Work

- My headaches never interfere with work activity
- My headaches rarely interfere with work activity
- My headaches interfere moderately with work activities
- My headaches interfere very much with work activities
- My headaches prevent me from doing most jobs
- My headaches prevent me from doing any work.

8.) How much do your headaches interfere with your social activities (family, friends, neighbors, or groups)?

- Never
- Rarely
- Slightly
- Moderately
- Frequently
- Extremely

9.) In the past four weeks, how much time have you missed from work, school, or usual activities because of headaches?

- None
- One to three days
- Four days to one week
- One to two weeks
- Two to three weeks
- Three to four weeks

10.) Medication

- I never take medication
- I very rarely take medication
- I sometimes take medication
- I frequently take medication
- I use medication most days



NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Section 1---- Pain Intensity

- I have no pain at the moment.
- The pain is very mild.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2---- Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help, but manage most of my personal care.
- I need help ever day in most aspects of self care.
- I do not get dressed; I wash with difficulty and stay in bed.

Section 3---- Lifting

- I can lift heavy weights, without extra pain
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

Section 4---- Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I cannot read as much as I want because of moderate pain in my neck.
- I cannot read at all.

Section 5---- Headaches

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequent.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Section 6---- Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

Section 7---- Work

- I can do as much as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

Section 8----Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I cannot drive my car at all.

Section 9---- Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1-2 hours sleepless).
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours sleepless).

Section 10---- Recreation

- I am able to engage in all of my recreational activities, with no neck pain at all.
- I am able to engage in all of my recreational activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- I am able to engage in a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I cannot do any recreational activities at all.

Patient Signature: _____ Date: _____



Palmetto Chiropractic

Neck & Back Center of the Pee Dee, LLC.

Letter of No Accident or Injury

I, _____ hereby state with my signature below that I was not involved in any auto accident, slip and fall, or work-related injury. My treatment is in no way associated with an 3rd party, and no other party is responsible or liable for the cost of my treatment; therefore, please process and pay all claims immediately.

Thank you for your attention to this matter.

Sincerely,

Patient Signature

Date



Palmetto Chiropractic

Neck & Back Center of the Pee Dee, LLC.

To: _____

Re: Authorization to Release Medical Information

You are hereby authorized to forward to Palmetto Chiropractic Neck & Back Center any and all information or medical records regarding the undersigned, including history and physical, laboratory and x-ray reports, with diagnosis and treatment.

Name of Patient: _____

Signature: _____

Date of Birth: _____

Social Security Number: _____

Date: _____

Witness: _____



When your back hurts, you may find it difficult to do some of the things you normally do.

This list contains some sentences that people have used to describe themselves when they have back pains. When you read them, you may find that some stand out because they describe you today. As you read this list, think of yourself today. Check the box next to any sentence that describes you today. If the sentence does not describe you, then leave the space blank and go on to the next one. **Remember, only check the sentence if you are sure that it describes you TODAY.**

- I stay at home most of the time because of my back.
- I change positions frequently to try and get my back comfortable.
- I walk more slowly than usual because of my back.
- Because of my back I am not doing any of the jobs I usually do around the house.
- Because of my back, I use a handrail to get upstairs.
- Because of my back, I lie down to rest more often.
- Because of my back, I have to hold on to something to get out of an easy chair.
- Because of my back, I try to get other people to do things for me.
- I get dressed more slowly than usual because of my back.
- I only stand up for short periods of time because of my back.
- Because of my back, I try not to bend or kneel down.
- I find it difficult to get out of a chair because of my back.
- My back is painful almost all of the time.
- I find it difficult to turn over in bed because of my back.
- My appetite is not very good because of my back.
- I have trouble putting on my socks (or stockings) because of the pain in my back.
- I only walk short distances because of my back pain.
- I sleep less well because of my back.
- Because of my back pain, I get dressed with the help of someone else.
- I sit down for most of the day because of my back.
- I avoid heavy jobs around the house because of my back.
- Because of my back pain, I am more irritable and bad tempered with people than usual.
- Because of my back, I go upstairs more slowly than usual.
- I stay in bed most of the time because of my back.

On the scale below, please place one "X" that indicates how you are feeling today.

No Symptoms At All	Unbearable Pain

Patient
Signature _____

Date _____



**ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION
("Agreement")**

I, the undersigned, hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payees"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("condition") to pay directly to and exclusively in the name of Palmetto Chiropractic Neck and Back Center ("office") such sums as may be owing to Palmetto Chiropractic Neck and Back Center for charges incurred by me, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the Office ("charges"). I further grant a contractual lien to Palmetto Chiropractic Neck and Back Center with respect to my charges, applicable to all payers, however, I understand that nothing in this Agreement shall be construed as an election by Palmetto Chiropractic Neck and Back Center to claim protection under any statutory lien law. For the purposes of this Agreement, "benefits" shall include, but not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, lost wage benefits, lost services benefit, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker's compensation benefits, malpractice proceeds, and any other benefits or proceeds payable to me for the purpose stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay Palmetto Chiropractic Neck and Back Center, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Palmetto Chiropractic Neck and Back Center to extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action either in my name or in the Office's name and to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct each attorney to provide immediate notice of to the Office regarding any funds received by the attorney relating to my accident, to promptly pay such Office, and to provide full accounting of such funds to the Office upon its request.

I hereby direct all payers to release to Palmetto Chiropractic Neck and Back Center any information regarding any coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Palmetto Chiropractic Neck and Back Center to endorse/sign my name on any and all checks listing me as a payee, which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize Palmetto Chiropractic Neck and Back Center to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due Palmetto Chiropractic Neck and Back Center for their services. This Assignment and Lien does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Palmetto Chiropractic Neck and Back Center for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of Palmetto Chiropractic Neck and Back Center and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Assignment and Lien.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interest of Palmetto Chiropractic Neck and Back Center and myself. However, should any provision of this Agreement be found to be invalid, illegal, or unenforceable or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (please print): _____

Patient Signature: _____

Date: _____

Name of Custodial Parent or Legal Guardian (please print): _____

Parent/Guardian Signature: _____

Witness: _____

Date: _____



Palmetto Chiropractic

Neck & Back Center of the Pee Dee, LLC.

***If yours is an accident injury,
please complete the following questions.***

Date of Accident: _____ Hour: _____ (AM) (PM)

Location: _____

How did the accident occur? (ie, auto collision, on the job injury, etc.)

If an auto collision, please describe.

If not an auto collision, please describe the circumstances.

If an auto collision, were you: Driver Passenger Pedestrian

Were there any other persons in the car with you? If so, who?

Did you have your seatbelt on? Yes No

Did an ambulance come to the scene of the accident? Yes No

Did you go to the Emergency Room? Yes No

If yes, where? _____

Have you seen any other doctor for this condition? Yes No

If yes, who? _____

Was your vehicle moving at the time of the impact? Yes No

If yes, approximately how fast? _____

If auto collision, were you struck from

 behind right side left side front vehicle was parked

Did your car strike the other (s) involved? Yes No

Did the other car strike you? Yes No

Have you lost any days of work? Yes No

If yes, what dates? _____

Patient's Signature

Date