DATE: _____

Palmetto ChiroMed

491 West Cheves St
Florence SC 29501
843-662-8000

PATIENT INFORMATION:

Patient Name: _____
Last Name First Name Middle Initial

Date of Birth: _____ Age:_____ Sex: _____Male _____Female SS#/Patient ID#: _____

Address: _____

City: _____ State _____ Zip Code _____

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

Email address: _____

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____ Spouse's Date of birth _____

Referred by: _____

Emergency Contact:

Name: _____

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

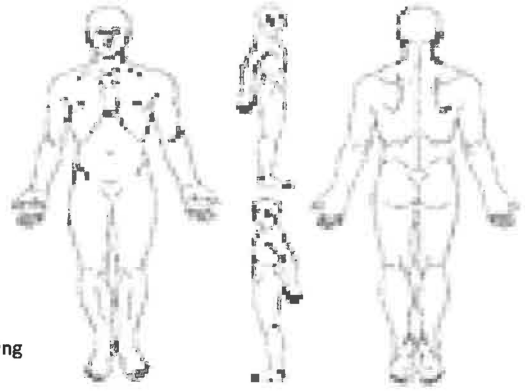
Patient Condition:

Reason for visit: _____

When did your symptoms appear or begin? _____

Is this condition getting progressively worse? _____Yes _____No

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 to 10: _____ (1 least pain and 10 severe pain)

How often do you have this pain? _____

Is it consistent or does it come and go? _____

Does it interfere with your _____Work _____Sleep _____Daily Routine _____Recreation

Are any painful to perform: _____Siting _____Standing _____Walking _____Bending _____Lying Down

What type of pain are you having: _____Dull _____Throbbing/Numbness/Aching _____ Shooting _____Burning
_____ Tingling _____ Cramps _____ Stiffness _____Swelling _____ Other

Insurance Information (If applicable):

I certify that I, and/or my dependent(s) have insurance coverage with _____ And assign directly to Palmetto ChiroMed 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 ChiroMed 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

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Neck Index Score _____

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

HEALTH INFORMATION

GENERAL INFORMATION:

_____ _____
First Name Middle Initial Last Date of Birth

Patient Height _____ **Patient Weight** _____ **Patient Blood Pressure** _____

Race: (circle ONLY 1)

American Indian
Asian
Black or African American
Native Hawaiian
Alaska Native
White
Other Pacific Islander
Declined to state

Ethnicity (check ONLY 1)

_____Declined to state _____Hispanic or Latino _____Not Hispanic or Latino

Preferred Language: _____

Email Address: _____

Smoking Status (check ONLY 1)

_____Current every day Smoker Smoking start date: _____ End date: _____
_____Current some day smoker _____Former Smoker _____I have never smoked
In an effort to stop smoking, I am currently taking: _____

Do you have any allergies to medication? YES NO

If yes, please indicate the following (if you need additional space, please use the other side of this sheet):

Allergy: _____ Reaction: _____

Start date: _____ End Date: _____

Are you currently taking any medications? YES NO

If yes, please indicate the following (if you need additional space, please use other side of this sheet):

Medication: _____ Frequency: _____

Route: _____Oral _____Intravenous

Other: _____

Date you started use: _____ Date you discontinued use: _____

Family Medical History (Please list any known medical conditions your family has had):

Condition: _____ Relationship to patient: _____

Condition: _____ Relationship to patient: _____

Condition: _____ Relationship to patient: _____

Condition: _____ Relationship to patient: _____

HEALTH HISTORY

What treatment have you already received for your condition? ____Medication _____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 disorder	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 Type _____	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**	
___None	___Sitting	___Smoking	Packs/day_____
___Moderate	___Standing	___Alcohol	Drinks/week_____
___Daily	___Light Labor	____Coffee/Caffeine	Drinks-Cups/Day_____
___Heavy	___Heavy Labor	____High Stress Level	Reason _____

Are you pregnant? ___YES ___NO If yes, what is your due date? _____

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

_____

Medications Allergies Vitamins/Herbs\Minerals

_____

_____

_____

(Please use other side if additional space is needed)

Pharmacy Name: _____ Pharmacy Address: _____

Patient signature: _____ Date: _____

Palmetto ChiroMed

Please answer the following questions and sign below

(If any question 1-7 is checked "Yes", Patient **MUST** see Celista **PRIOR** to treatment)

Do You Have a Medical History of the Following:

1. Pacemaker? _____Yes _____No
2. ICD (Implantable Cardioverter Defibrillator)? _____Yes _____No
3. Seizures? _____Yes _____No
4. Paralysis, stroke, multiple sclerosis? _____Yes _____No
5. Do you have any skin conditions? _____Yes _____No
6. Are you being treated for cancer? _____Yes _____No
7. Loss of sensation (means that you can't feel pain, heat, or cold)? _____Yes _____No
8. Have you ever had any neck, upper or lower back surgery? _____Yes _____No
9. Do you have any numbness, tingling or weakness due to a medical condition not related to your accident? _____Yes _____No
10. Are you pregnant or is there a possibility you may be? _____Yes _____No
11. Are you breastfeeding? _____Yes _____No

If at anytime any of the above conditions become part of your medical history please inform staff immediately!

By signing below, I acknowledge that I have read and answered the above questions truthfully and to the best of my knowledge. I also understand that if at any time I have any of the above conditions, it is my responsibility to notify a staff member as soon as possible. If you have any questions, please let us know.

Patient Signature: _____ Date: _____

Chiro Assistant 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 ChiroMed ("office") such sums as may be owing to Palmetto ChiroMed 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 ChiroMed 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 ChiroMed 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 ChiroMed, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Palmetto ChiroMed 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 ChiroMed 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 ChiroMed 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 ChiroMed 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 whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due Palmetto ChiroMed 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 ChiroMed 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 ChiroMed 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 reasonable necessary for the protection of the rights and interest of Palmetto ChiroMed 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: _____ DATE: _____

Witness: _____ DATE: _____

Authorization for use and Disclosure of Health Information

While the law requires us to give you this disclosure, please understand that we respect the privacy of your health information. However, there are some circumstances in which we may disclose your health information.

We may disclose your health information to another health care provider or a hospital if it is necessary to refer you to diagnosis, assessment, or treatment.

We may disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

We may use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed, which you have the right to review before signing this form (164.520). We reserve the right to change our privacy policy but will notify you in writing of any changes either through the mail or when you come in for treatment. You may request a copy of our privacy policy at any time.

Your chiropractor and members of the practice staff may use your name, address, phone number, and clinical records to contact you with appointment reminders, information about treatment or other health related information. If contact is made by phone, a message may be left on your voicemail or answering device. By signing this form, you are giving us authorization to contact you in this manner.

Information that we disclose based on this authorization may be subject to re-disclosure by anyone who has access to the communication and may no longer be protected by the federal privacy rules.

You have the opportunity to designate a family member or another individual as a person with whom we may discuss your condition and treatment plan.

You may restrict the individuals or organizations to which your health care information may be released by notifying us in writing. We are not required to agree to your restrictions; however, if we do agree, the restriction is binding on us. You may revoke your authorization to us at any time, but your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse to give us this authorization. This decision will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I acknowledge that I have read and received a copy of this policy and authorization request, and I hereby agree to the terms and authorize you to disclose my health information in the manner described above. This authorization is effective as of the date printed below and will expire seven years after the ate on which you last received services from us.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM TE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM: _____

_____ _____

Patient or Legal Guardian PRINTED NAME | Authorized Provider Representative

_____ _____

Patient or Legal Guardian SIGNATURE | Date

To: _____

Re: **Authorization to Release Medical Information**

You are hereby authorized to forward to Palmetto ChiroMed any and all information or medical records regarding the undersigned, including history and physical, laboratory and x-ray reports, with diagnosis and treatment. Please also include any discharge medication list.

Name of Patient: _____

Date of Birth: _____ Last (4) Digits of SSN: _____

Treatment Date(s) Most recent visit in your office

Primary Care Physician Name
and/or Last Place of Medical Treatment: _____

Address: _____

Telephone No: _____

_____I am declining this request and acknowledge by signing below that I do not want Palmetto ChiroMed to obtain my medical records from any of my providers.

Patient/Guardian Signature: _____

Date: _____

Palmetto Chiromed LLC
491 W. Cheves St Suite A
Florence, SC 29501
Phone: 843-662-8000

If records can be emailed please send to:
Amanda@palmettochiro.com

otherwise please fax to: (843) 664-0994

Diagnostic Imaging/X-Ray Pregnancy Consent

Patient Name:_____

Patient DOB: _____

Please Answer the Following Questions: (Females Only 12-55 years of age)

Are you pregnant or any chance you may be:_____YES_____NO

The exam your doctor has ordered uses Ionizing radiation which can have a severe health effect during pregnancy to an unborn baby. The possibility of severe health effects depends on the gestational age of the unborn baby at the time of exposure and the amount of radiation it is exposed to. Unborn babies are particularly sensitive to radiation during their early development, between weeks 2 and 15 of pregnancy. Such consequences can include stunted growth, deformities, abnormal brain function, or cancer that may develop sometime later in life. You should contact your doctor if you believe you may be pregnant to discuss possible side effects and the risks and benefits of the procedure. If you feel that you may be pregnant, please inform the radiologic technologist before your exam.

_____To the best of my knowledge, I am not pregnant or believe there is any possibility that I may be pregnant.

_____I know or believe that I may be pregnant and fully understand the risk and health effects radiation may cause to my unborn baby.

Signature:_____ Date: _____