



Carolina Sports, Spine & Wellness Center, PLLC
 222 S. Swing Rd., Suite 5
 Greensboro, NC 27409
 p 336.763.3756
 f 336.763.3757
 carolinasportspine.medicfusion.com

Patient: _____

AUTHORIZATIONS AND RELEASES

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time.

Initials: _____

Consent to Perform and Interpret X-rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate.

I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.

Initials: _____

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. For more information about Health Information Portability and Accountability Act (HIPAA) and health information privacy visit: [hhs.gov - Understanding Health Information Privacy](https://www.hhs.gov/understanding-health-information-privacy)

- The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
- The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
- The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
- This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
- Patients have the right to file a formal complaint with our privacy official about any suspected violations.
- This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initials: _____



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Financial Obligation and Appointment Policy

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.

You may direct any questions regarding this financial obligation to the clinic manager or physician.

Initials: _____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor and certified staff have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to a fetus.

Initials: _____

Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

Initials: _____

Insurance / Medicare payment-Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct.

I authorize this office and/or doctor to act as my agent in helping me obtain payment of my insurance and/ or Medicare benefits, and I authorize payment of these benefits to this clinic and/or doctor of record on my behalf for any services and materials furnished.

Initials: _____

Consent to Chiropractic Treatment

Please read this entire section regarding chiropractic care prior to accepting it. It is important that you understand the information contained in this section. Please ask questions before you accept it if there is anything that is unclear. You are the decision maker for your health care. Part of the role of this clinic is to provide you with information to assist you in making informed choices. This process is often referred to as 'informed consent' and involves your understanding and agreement regarding the care that this clinic recommends, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. The nature of the chiropractic analysis and treatment The primary treatment that is performed by a Doctor of Chiropractic is spinal manipulative therapy. This clinic may use that procedure to treat you. This may include the use of the hands or a mechanical instrument upon your body in such a way as restore normal joint motion. It may cause an audible 'pop' or 'click,' much as you have experienced when you 'crack' your knuckles. You may feel a sense of movement. Analysis/ Examination / Treatment As a part of the analysis, examination, and treatment, the doctor may want to employ a variety of procedures as may be deemed necessary. These procedures include but are not limited to: Spinal manipulative therapy, chiropractic adjustments, vital signs, range of motion



testing, palpation, orthopedic testing, basic neurological testing, postural analysis testing, muscle strength testing, radiographic studies, scanning of feet, EMS, exercises, acupuncture, myofascial treatments, hot/cold therapy, mechanical traction, traction/decompression, laser therapy, vibrational pivot platform, or cranial balloon adjustments (CFR). By accepting this document you are consenting to these procedures as recommended/prescribed by this clinic. The material risks inherent in chiropractic adjustment. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation or from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an 'arterial dissection' that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which the provider will check during the taking of your history during examination and X-ray. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admissions attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons and the risk of death has been estimated at 140 per one million users. The availability and nature of other treatment options. Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted other treatment options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. The risks and dangers to remaining untreated. Remaining untreated may allow the formulation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed with the clinic any questions and concerns I have and they have been answered to my satisfaction. By accepting, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Initials: _____

Females: Consent to X-Ray During Pregnancy

This is to certify that, I am or may be pregnant and that the doctor or certified staff has my permission to perform diagnostic x-rays involving any cervical spine (neck) or extremities (arms or legs), on the condition that lead shielding be used over the trunk of my body. I have been advised that certain x-rays, particularly those involving the pelvis, can be hazardous to a fetus.

Initials: _____

Signature: _____ Date: _____



Patient Profile

Personal Information

Full Name: Last First M.I. Jr / Sr

Address: Street Address Apartment/Unit #
City State ZIP Code

Primary Phone: H / M / B Alternate Phone: H / M / B

Birth Date: / /

Social Security Number #: - -

Gender: Male Female

Race: American Indian or Alaska Native Asian Black or African American
Native Hawaiian or Other Pacific Islander White Declined Unknown/Unavailable
Other

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined Unknown/Unavailable

Prim. Language: Arabic Chinese English French German Greek Hebrew Italian
Japanese Korean Spanish Vietnamese Declined Unknown/Unavailable
Other

Email Address:

Emergency Contact: Emergency Contact Phone:

Time Zone:

Does your time zone participate in Daylight Savings Time? Yes No

Marital Status: Single Married Widowed Divorced

Do you have any dependents? Yes No

Are you a full-time student? Yes No

Health Insurance? Yes No

Responsible Party: You Other (parent, spouse, etc.)



Physician Form

Physician Information

Type of Physician: Chiropractic Family Specialist

Physician Name: _____
First Name Last Name

Address: _____
Street Address Unit #

City State ZIP Code

Phone: _____ Ext. _____ Fax: _____

Email Address: _____

Type of Physician: Chiropractic Family Specialist

Physician Name: _____
First Name Last Name

Address: _____
Street Address Unit #

City State ZIP Code

Phone: _____ Ext. _____ Fax: _____

Email Address: _____

Type of Physician: Chiropractic Family Specialist

Physician Name: _____
First Name Last Name

Address: _____
Street Address Unit #

City State ZIP Code

Phone: _____ Ext. _____ Fax: _____

Email Address: _____



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Employer Form

Employer Information

Your Employment Status: Full Time Part Time Contract Not Employed Retired Student

Occupation or Title: _____

Employer Name: _____

Employer Address: _____
Street Address Apartment/Unit #

_____ _____
City State ZIP Code

Employer Phone: _____ Ext. _____ Fax: _____

Start Date: _____ / _____ / _____ End Date: (If you are no longer working here.) _____ / _____ / _____

Your Employment Status: Full Time Part Time Contract Not Employed Retired Student

Occupation or Title: _____

Employer Name: _____

Employer Address: _____
Street Address Apartment/Unit #

_____ _____
City State ZIP Code

Employer Phone: _____ Ext. _____ Fax: _____

Start Date: _____ / _____ / _____ End Date: (If you are no longer working here.) _____ / _____ / _____

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Responsible Party Form

Responsible Party Information

Relationship to You: _____

Full Name: _____
First M.I. Last

Same as your address? Yes No

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

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Health Insurance Information

Are you the insured party? Yes No (if no please fill out the Policy Holder Information)

Policy Holder Information

Full Name: _____
Last First M.I.

Relationship to you: _____

Address: _____
Street Address Apartment/Unit #

_____ *City State ZIP Code*

Birth Date: _____ / ____ / ____

Social Security Number #: _____ - ____ - ____

Insured's Occupation: _____

Insured's Employer: _____

Employer Address: _____
Street Address Unit #

_____ *City State ZIP Code*

Employer Phone: _____ Ext. _____

Insurance Company Information

Insurance Company Name: _____

Address: _____
Street Address Unit #

_____ *City State ZIP Code*

Phone: _____ Ext. _____ Fax: _____

Group #: _____

Policy/Subscriber #: _____

Effective Date: _____ / ____ / ____ Expiration Date: _____ / ____ / ____

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Patient: _____

Health History Form

Prescription Medications

Prescription medications taken on a regular or ongoing basis:

Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						

Over-The-Counter Medications

Over-the-counter medications taken on a regular or ongoing basis:

Medication: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Medication: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Medication: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Medication: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Medication: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Medication: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Medication: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Medication: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Medication: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Medication: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Medication: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____



Vitamins, Minerals, Herbs, or Dietary Supplements

Vitamins, minerals, herbs, or dietary supplements taken on a regular or ongoing basis:

Supplement: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Supplement: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Supplement: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Supplement: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Supplement: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Supplement: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Supplement: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Supplement: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Supplement: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Supplement: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____

Supplement: _____ Dosage: _____ Frequency: per Day Week Month Other
 (please describe): _____



Diet and Exercise

Check if you have ever smoked cigars or cigarettes. Yes

Check if you still smoke. Yes

How much do you smoke? Less than one pack per week 1-2 packs per week
 1 pack every two days 1 pack per day More than one pack per day

Check if you drink alcoholic beverages. Yes

How many alcoholic beverages do you consume per week? _____

Check if a physician has ever diagnosed you as an alcoholic. Yes

Check if a physician has ever diagnosed you with any liver-related problems. Yes

Check if you exercise regularly. Yes

How many days do you exercise each week? _____

Allergies

Check if a physician has ever diagnosed you with any allergies. Yes

Do you have Airborne allergies? Yes

- | | | | |
|-----------------------------------|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Animal | <input type="checkbox"/> Molds/Fungus | <input type="checkbox"/> Pollens | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cat Hair | <input type="checkbox"/> Cockroach | <input type="checkbox"/> Dog Hair | <input type="checkbox"/> Feather Mix |
| | <input type="checkbox"/> Guinea Pig Hair | <input type="checkbox"/> Dust Mites | <input type="checkbox"/> Other _____ |

Do you have Chemical allergies? Yes

- | | | | | |
|---|---|---|--|------------------------------------|
| <input type="checkbox"/> Acetone | <input type="checkbox"/> Acetylcholine | <input type="checkbox"/> Auto Exhaust | <input type="checkbox"/> Benzyl Alcohol | <input type="checkbox"/> Chlorine |
| <input type="checkbox"/> Citric Acid | <input type="checkbox"/> Cologne (all) | <input type="checkbox"/> Diesel Exhaust | <input type="checkbox"/> Dopamine | <input type="checkbox"/> Estradiol |
| <input type="checkbox"/> Ethanol | <input type="checkbox"/> Fluorine | <input type="checkbox"/> Formaldehyde | <input type="checkbox"/> Latex | <input type="checkbox"/> Melatonin |
| <input type="checkbox"/> Newspaper Print | <input type="checkbox"/> Norepinephrine | <input type="checkbox"/> Progesterone | <input type="checkbox"/> Propylene | <input type="checkbox"/> Serotonin |
| <input type="checkbox"/> Silicone Implant | <input type="checkbox"/> Sponge Rubber | <input type="checkbox"/> Toluene | <input type="checkbox"/> Trichloroethylene | <input type="checkbox"/> Wood Pulp |
| | | <input type="checkbox"/> Xylene | <input type="checkbox"/> Other _____ | |

Do you have Drug allergies? Yes

- | | | | | |
|--|-------------------------------------|---|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Anticonvulsants | <input type="checkbox"/> Codeine | <input type="checkbox"/> Insulin Preparations | <input type="checkbox"/> Iodine | <input type="checkbox"/> Morphine |
| <input type="checkbox"/> Novocain | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Other _____ | |

Do you have Food allergies? Yes

- | | | | | |
|---|--|-------------------------------------|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Artificial Colorings | <input type="checkbox"/> Artificial Flavorings | <input type="checkbox"/> Beef | <input type="checkbox"/> Coffee/Tea | <input type="checkbox"/> Dairy |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish/Shellfish | <input type="checkbox"/> Fruits | <input type="checkbox"/> Lamb | <input type="checkbox"/> Nuts |
| <input type="checkbox"/> Pork | <input type="checkbox"/> Poultry | <input type="checkbox"/> Vegetables | <input type="checkbox"/> Other _____ | |



Surgical History

Check if you have any implants, screws, plates or other foreign objects in your body. Yes

- Bullet Wound(s) Infusion Catheter Ear Implant Pacemakers Eye Implant
 Brain Plate(s) Heart Valve(s) Shrapnel Other _____

Musculoskeletal Surgeries (Check if you have had any of the following surgeries)

- | | | | |
|---|---------------------------|-----------------------------------|---------------------------|
| <input type="checkbox"/> Ankle | Year(s) of surgery: _____ | <input type="checkbox"/> Head | Year(s) of surgery: _____ |
| <input type="checkbox"/> Back | Year(s) of surgery: _____ | <input type="checkbox"/> Hip | Year(s) of surgery: _____ |
| <input type="checkbox"/> Cosmetic or Augmentation | Year(s) of surgery: _____ | <input type="checkbox"/> Knee | Year(s) of surgery: _____ |
| <input type="checkbox"/> Elbow | Year(s) of surgery: _____ | <input type="checkbox"/> Neck | Year(s) of surgery: _____ |
| <input type="checkbox"/> Foot | Year(s) of surgery: _____ | <input type="checkbox"/> Shoulder | Year(s) of surgery: _____ |
| <input type="checkbox"/> Hand | Year(s) of surgery: _____ | <input type="checkbox"/> Wrist | Year(s) of surgery: _____ |
| <input type="checkbox"/> Other | Please describe: _____ | | Year(s) of surgery: _____ |

Organ System Surgeries (Check if you have had any of the following surgeries)

- | | | | |
|---|---------------------------|--|---------------------------|
| <input type="checkbox"/> Brain | Year(s) of surgery: _____ | <input type="checkbox"/> Intestine, large | Year(s) of surgery: _____ |
| <input type="checkbox"/> Colon | Year(s) of surgery: _____ | <input type="checkbox"/> Liver | Year(s) of surgery: _____ |
| <input type="checkbox"/> Esophagus | Year(s) of surgery: _____ | <input type="checkbox"/> Lung | Year(s) of surgery: _____ |
| <input type="checkbox"/> Eye | Year(s) of surgery: _____ | <input type="checkbox"/> Mastectomy | Year(s) of surgery: _____ |
| <input type="checkbox"/> Heart | Year(s) of surgery: _____ | <input type="checkbox"/> Reproductive Organs | Year(s) of surgery: _____ |
| <input type="checkbox"/> Kidney | Year(s) of surgery: _____ | <input type="checkbox"/> Skin | Year(s) of surgery: _____ |
| <input type="checkbox"/> Intestine, small | Year(s) of surgery: _____ | <input type="checkbox"/> Throat | Year(s) of surgery: _____ |
| <input type="checkbox"/> Other | Please describe: _____ | | Year(s) of surgery: _____ |
| <input type="checkbox"/> Transplant | Please describe: _____ | | Year(s) of surgery: _____ |

Your Cancer History

Check if a physician has ever diagnosed you with cancer. Yes

Check all that apply

- | | |
|--|--|
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Lung |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Non-Hodgkin's Lymphoma |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Ovarian |
| <input type="checkbox"/> Cervical | <input type="checkbox"/> Pancreatic |
| <input type="checkbox"/> Colon or Rectal | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Endometrial | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Eye | <input type="checkbox"/> Basal Cell Carcinoma |
| <input type="checkbox"/> Kidney (renal cell) | <input type="checkbox"/> Squamous Cell Carcinoma |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Stomach |
| | <input type="checkbox"/> Thyroid |
| | <input type="checkbox"/> Uterine |

Family Cancer History

Check if a physician has ever diagnosed your family with cancer. Yes

Check all that apply and the family member(s) who had this condition:

- | | |
|--|--|
| <input type="checkbox"/> Bladder (M, F, S, MG, PG) | <input type="checkbox"/> Lung (M, F, S, MG, PG) |
| <input type="checkbox"/> Brain (M, F, S, MG, PG) | <input type="checkbox"/> Non-Hodgkin's Lymphoma (M, F, S, MG, PG) |
| <input type="checkbox"/> Breast (M, F, S, MG, PG) | <input type="checkbox"/> Ovarian (M, F, S, MG, PG) |
| <input type="checkbox"/> Cervical (M, F, S, MG, PG) | <input type="checkbox"/> Pancreatic (M, F, S, MG, PG) |
| <input type="checkbox"/> Colon or Rectal (M, F, S, MG, PG) | <input type="checkbox"/> Prostate (M, F, S, MG, PG) |
| <input type="checkbox"/> Endometrial (M, F, S, MG, PG) | <input type="checkbox"/> Skin (M, F, S, MG, PG) |
| <input type="checkbox"/> Eye (M, F, S, MG, PG) | <input type="checkbox"/> Basal Cell Carcinoma (M, F, S, MG, PG) |
| <input type="checkbox"/> Kidney (renal cell) (M, F, S, MG, PG) | <input type="checkbox"/> Squamous Cell Carcinoma (M, F, S, MG, PG) |
| <input type="checkbox"/> Leukemia (M, F, S, MG, PG) | <input type="checkbox"/> Melanoma (M, F, S, MG, PG) |
| <input type="checkbox"/> Other _____ (M, F, S, MG, PG) | <input type="checkbox"/> Stomach (M, F, S, MG, PG) |
| | <input type="checkbox"/> Thyroid (M, F, S, MG, PG) |
| | <input type="checkbox"/> Uterine (M, F, S, MG, PG) |

Family Members	
(M)	Mother
(F)	Father
(S)	Sibling
(MG)	Maternal Grandparent
(PG)	Paternal Grandparent

Your Cardio-pulmonary / Circulatory Health

Check if a physician has ever diagnosed you with any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Hypotension (low blood pressure) |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Lung Disorders |
- | | |
|--|---|
| <input type="checkbox"/> Acute Respiratory Distress Syndrome | <input type="checkbox"/> Alpha-1 Antitrypsin Deficiency |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Asbestos/Dust Disease |
| <input type="checkbox"/> Bronchitis (chronic) | <input type="checkbox"/> Bronchiectasis |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease | <input type="checkbox"/> Bronchopulmonary Dysplasia (BPD) |
| <input type="checkbox"/> Farmer's Lung | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Histoplasmosis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Lymphangioleiomyomatosis | <input type="checkbox"/> Hantavirus |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Legionellosis |
| <input type="checkbox"/> Primary Alveolar Hypoventilation Syndrome | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Pulmonary Fibrosis | <input type="checkbox"/> Pneumothorax |
| <input type="checkbox"/> Respiratory Syncytial Virus | <input type="checkbox"/> Pulmonary Alveolar Proteinosis |
| <input type="checkbox"/> Severe Acute Respiratory Syndrome | <input type="checkbox"/> Pulmonary Embolus |
| | <input type="checkbox"/> Respiratory Distress Syndrome |
| | <input type="checkbox"/> Sarcoidosis |
| | <input type="checkbox"/> Spontaneous Pneumothorax |
| | <input type="checkbox"/> Tuberculosis |
- | | |
|---|---|
| <input type="checkbox"/> Raynaud's Phenomenon | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Sinus Infections (chronic) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Wegener's Granulomatosis | <input type="checkbox"/> Other _____ |

Family Cardio-pulmonary / Circulatory Health

Check if a physician has ever diagnosed your family with any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Anemia (M, F, S, MG, PG) | <input type="checkbox"/> HIV/AIDS (M, F, S, MG, PG) |
| <input type="checkbox"/> Hemophilia (M, F, S, MG, PG) | <input type="checkbox"/> Hepatitis (M, F, S, MG, PG) |
| <input type="checkbox"/> Hypertension (high blood pressure) (M, F, S, MG, PG) | <input type="checkbox"/> Hypotension (low blood pressure) (M, F, S, MG, PG) |
| <input type="checkbox"/> Hemorrhoids (M, F, S, MG, PG) | <input type="checkbox"/> Lung Disorders (M, F, S, MG, PG) |

<input type="checkbox"/> Acute Respiratory Distress Syndrome (M, F, S, MG, PG)	<input type="checkbox"/> Alpha-1 Antitrypsin Deficiency (M, F, S, MG, PG)
<input type="checkbox"/> Asthma (M, F, S, MG, PG)	<input type="checkbox"/> Asbestos/Dust Disease (M, F, S, MG, PG)
<input type="checkbox"/> Bronchitis (chronic) (M, F, S, MG, PG)	<input type="checkbox"/> Bronchiectasis (M, F, S, MG, PG)
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease (M, F, S, MG, PG)	<input type="checkbox"/> Bronchopulmonary Dysplasia(BPD) (M, F, S, MG, PG)
<input type="checkbox"/> Farmer's Lung (M, F, S, MG, PG)	<input type="checkbox"/> Cystic Fibrosis (M, F, S, MG, PG)
<input type="checkbox"/> Histoplasmosis (M, F, S, MG, PG)	<input type="checkbox"/> Emphysema (M, F, S, MG, PG)
<input type="checkbox"/> Lymphangiomyomatosis (M, F, S, MG, PG)	<input type="checkbox"/> Hantavirus (M, F, S, MG, PG)
<input type="checkbox"/> Pneumonia (M, F, S, MG, PG)	<input type="checkbox"/> Legionellosis (M, F, S, MG, PG)
<input type="checkbox"/> Primary Alveolar Hypoventilation Syndrome (M, F, S, MG, PG)	<input type="checkbox"/> Pleurisy (M, F, S, MG, PG)
<input type="checkbox"/> Pulmonary Fibrosis (M, F, S, MG, PG)	<input type="checkbox"/> Pneumothorax (M, F, S, MG, PG)
<input type="checkbox"/> Respiratory Syncytial Virus (M, F, S, MG, PG)	<input type="checkbox"/> Pulmonary Alveolar Proteinosis (M, F, S, MG, PG)
<input type="checkbox"/> Severe Acute Respiratory Syndrome (M, F, S, MG, PG)	<input type="checkbox"/> Pulmonary Embolus (M, F, S, MG, PG)
(M, F, S, MG, PG)	<input type="checkbox"/> Respiratory Distress Syndrome (M, F, S, MG, PG)
	<input type="checkbox"/> Sarcoidosis (M, F, S, MG, PG)
	<input type="checkbox"/> Spontaneous Pneumothorax (M, F, S, MG, PG)
	<input type="checkbox"/> Tuberculosis (M, F, S, MG, PG)

- | | |
|---|---|
| <input type="checkbox"/> Raynaud's Phenomenon (M, F, S, MG, PG) | <input type="checkbox"/> Sickle Cell Anemia (M, F, S, MG, PG) |
| <input type="checkbox"/> Sinus Infections (chronic) (M, F, S, MG, PG) | <input type="checkbox"/> Stroke (M, F, S, MG, PG) |
| <input type="checkbox"/> Wegener's Granulomatosis (M, F, S, MG, PG) | <input type="checkbox"/> Other _____ (M, F, S, MG, PG) |

Family Members	
(M)	Mother
(F)	Father
(S)	Sibling
(MG)	Maternal Grandparent
(PG)	Paternal Grandparent

Endocrine, Gastrointestinal and Neurologic Health

Check if a physician has ever diagnosed you with any of the following:

Autoimmune Disorder

<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Churg-Strauss (Allergic Granulomatosis)
<input type="checkbox"/> Eosinophilic Fasciitis	<input type="checkbox"/> Dermatomyositis/Polymyositis
<input type="checkbox"/> Goodpasture's Syndrome	<input type="checkbox"/> Interstitial Granulomatous Dermatitis
<input type="checkbox"/> Lupus	<input type="checkbox"/> with Arthritis
<input type="checkbox"/> Lupus SLE	
<input type="checkbox"/> Lupus DLE	
<input type="checkbox"/> Lupus SCLE	
<input type="checkbox"/> Anti-Phospholipid Antibody Syndrome (Lupus Anticoagulant)	
<input type="checkbox"/> Mixed Connective Tissue Disease	<input type="checkbox"/> Relapsing Polychondritis
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Sarcoidosis
<input type="checkbox"/> Scleroderma	<input type="checkbox"/> Sjogren's Syndrome
<input type="checkbox"/> Skin Immunofluorescence	<input type="checkbox"/> Vasculitis

Bladder Disease

Candida

Chicken Pox

Chronic Fatigue Syndrome

Crohn's Disease

Diabetes

Epilepsy

Fibromyalgia

Gall Bladder Problems

Headaches

Cluster Headaches

Migraine Headaches

Sinus Headaches

Stress-induced Headaches

Tension Headaches

Incontinence

Irritable Bowel Syndrome (IBS)

Kidney Disease

Liver Disease

Liver Problems

Measles

Mumps

Seizures

Shingles

Stomach Ulcers

Thyroid Dysfunction

Urinary Tract Infection

Other _____

Emotional and Mental Health

Check if a physician has ever diagnosed you with an emotional or mental condition. Yes

- | | |
|--|---|
| <input type="checkbox"/> Anger Disorders | <input type="checkbox"/> Anxiety Disorders |
| <input type="checkbox"/> Asperger Syndrome | <input type="checkbox"/> Attention Deficit Disorder with Hyperactivity (ADHD) |
| <input type="checkbox"/> Autistic Disorder | <input type="checkbox"/> Avoidant Personality Disorder (AvPD) |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Borderline Personality Disorder |
| <input type="checkbox"/> Capgras Syndrome | <input type="checkbox"/> Child Behavior Disorders |
| <input type="checkbox"/> Combat Disorders | <input type="checkbox"/> Cyclothymic Disorder |
| <input type="checkbox"/> Dependent Personality Disorder (DPD) | <input type="checkbox"/> Depressive Disorders (depression) |
| <input type="checkbox"/> Dissociative Disorders | <input type="checkbox"/> Dysthymic Disorders (mood disorder) |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Firesetting Behavior |
| <input type="checkbox"/> Hypochondriasis (Somatoform Disorder) | <input type="checkbox"/> Impulse Control Disorders |
| | <input type="checkbox"/> Kleine-Levin Syndrome |
| <input type="checkbox"/> Kleptomania | <input type="checkbox"/> Multiple Personality Disorder |
| <input type="checkbox"/> Munchausen Syndrome | <input type="checkbox"/> Narcissistic Personality Disorder |
| <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Obsessive Compulsive Disorder (OCD) |
| <input type="checkbox"/> Phobic Disorders (Phobias) | <input type="checkbox"/> Psychotic Disorders |
| <input type="checkbox"/> Restless Legs Syndrome | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Seasonal Affective Disorder | <input type="checkbox"/> Sexual or Gender Disorders |
| <input type="checkbox"/> Sexual Dysfunctions (psychological, not physical) | <input type="checkbox"/> Sleep Disorders |
| | <input type="checkbox"/> Post-traumatic Stress Syndrome |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Suicidal Tendencies |
| <input type="checkbox"/> Other _____ | |

Sensory Health

Check if a physician has ever diagnosed you with any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Cataract |
| <input type="checkbox"/> Cholesteatoma | <input type="checkbox"/> Deafness or Hearing Loss |
| <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Laryngitis (chronic) |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Meniere's Disease | <input type="checkbox"/> Nasal Polyps |
| <input type="checkbox"/> Perforated Eardrum | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Rhinitis | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Unusual Vision Impairment |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Other _____ |

Musculoskeletal Health

Check if a physician has ever diagnosed you with any of the following:

Arthritis

- | | |
|---|--|
| <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Behets Disease |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Diffuse Idiopathic Skeletal Hyperostosis (DISH) |
| <input type="checkbox"/> Ehlers-Danlos Syndrome (EDS) | <input type="checkbox"/> Felty's Syndrome |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Infectious Arthritis |
| <input type="checkbox"/> Mixed Connective Tissue Disease (MCTD) | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Paget's Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Polymyositis and Dermatomyositis | <input type="checkbox"/> Polymyalgia Rheumatica |
| <input type="checkbox"/> Reactive Arthritis | <input type="checkbox"/> Pseudogout |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Psoriatic Arthritis |
| <input type="checkbox"/> Sjogren's Syndrome | <input type="checkbox"/> Repetitive Stress Injury |
| | <input type="checkbox"/> Scleroderma |
| | <input type="checkbox"/> Stills Disease |

- | | |
|--|---|
| <input type="checkbox"/> Gout | <input type="checkbox"/> Herniated Disk |
| <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Numbness or Tingling in feet |
| <input type="checkbox"/> Numbness or Tingling in hands | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Temporomandibular Joint Syndrome (TMJ) |
| <input type="checkbox"/> Other _____ | |



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222 S. Swing Rd., Suite 5
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carolinasportspine.medicfusion.com

Reproductive Health

Check if you have ever given birth. Yes

How many births vaginally? _____

How many births by C-section? _____

Check if a physician has ever diagnosed you with any of the following:

- Chlamydia Dysplasia Erectile Dysfunction Genital Herpes
- Gonorrhea Human Papillomavirus (HPV) Impotency Syphilis
- Infertility Cystitis Menopause Prostate Enlargement
- Testicular Dysfunction Uterine Fibroid Vaginal Yeast Infections (chronic) Other _____

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 Greensboro, NC 27409
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 f 336.763.3757
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Patient: _____

New Case Questionnaire - Injury / Complaint Short Form

CHIEF COMPLAINT

Your current concern(s):

- Headaches Neck pain Low back pain Mid back pain Shoulder pain
 Elbow pain Hip pain Knee pain Other

Other concern(s):

When did your symptoms begin? If unknown please estimate:

[Female Patients] Are you pregnant? Yes No

If yes, estimate your due date: _____ If no, date of most recent menstrual cycle: _____

Which word best describes the frequency of your symptoms:

- Occasional (0-25%) Intermittent (26-50%) Frequent (51-75%) Constant (75-100%)

Which phrases best describe changes in your symptoms during the day? (select all that apply)

- Worse in the morning Worse in the afternoon Worse at night
 Changes with the weather Does not change

What helps to relieve your symptoms? (select all that apply)

- Ice Heat Medication Physical therapy
 Acupuncture Massage Nothing Other

Other relief:

What activities are limited by your symptoms? (select all that apply)

- Bending Bowel movement Coughing Daily routine
 Driving Getting up Lifting Lying down
 Pulling Pushing Reading Sitting
 Sleeping Sneezing Standing Turning head
 Urination Walking Working Other

Other activities:

Approximate date of your most recent Physical Exam:

Approximate date of your most recent Spinal x-ray:

Approximate date of your most recent MRI:

Approximate date of your most recent CT scan:

Approximate date of your most other scans:

Approximate date of your most recent Dental x-rays:

Other scans description:

PRIOR TREATMENT

Have you tried other medical treatments for this condition? Yes No

Specify treatment provider:

- Hospital or Urgent care
 Medical Physician
 Chiropractor
 Massage Therapist
 Physical Therapist
 Acupuncturist
 Other

Other treatment provider:

Start date of prior treatment:

End date of prior treatment:

This office requires a copy of the medical report detailing your treatment:

- I will provide a copy
 i will fax it
 I will e-mail it
 I authorize my former facility to release my records

Physician Information:

Name of Physician:

Name of facility:

Address:

City

State

Zip

Phone Number

ACCIDENT DETAILS

Are your symptoms a result of an accident?

- Yes
 No

Date of accident? If unknown, please estimate;

In what State did the accident happen?

What type of accident did you have?

- Other

Other accident information

Have you taken time of work as a result?

- Yes
 No

Are you still off work?

- Yes No

Beginning date

Ending date

Were you compensated for time lost from work?

- Yes No

ACCIDENT PARTIES

Is there an attorney handling your case?

- Yes No

Attorney information:

Attorney name:

Firm name:

Address:

City:

State:

Zip:

Phone number:

Fax number:

Email address:

Other financially involved party:

- Yes No Unknown

Other financially involved party information:

Name:

Address:

City:

State:

Zip:

Phone number:

Other insurance party:

Yes

No

Unknown

Other insurance party information

Contact name:

Company name:

Address:

City:

State:

Zip:

Phone number:

Fax number:

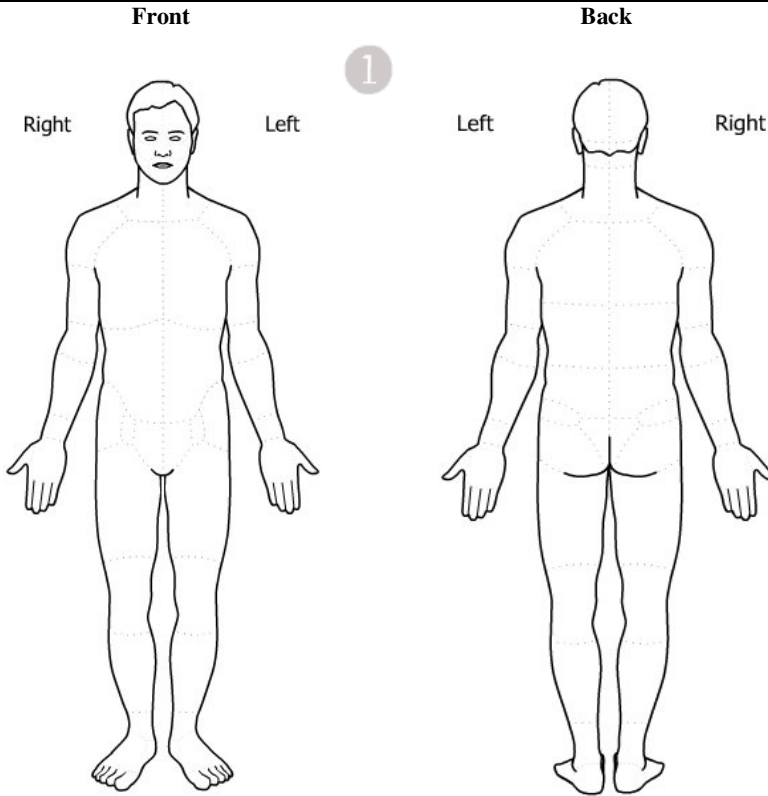
Email address:

Claim number:

Patient: _____

Patient Symptom Illustrator

Patient Symptom Illustrator



Instructions:

- 1 Identify your areas of discomfort by marking the affected body parts in the illustration.
- 2 Indicate the area name along with your specific symptoms associated with each selected area.
- 3 Rate your discomfort associated with each selected area.

		Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Swelling	Stiffness											
Ex.	L (R) Lower Back			X			X			X	0 = No Discomfort 10 = Severe Discomfort										
											0	1	2	3	4	5	6	7	8	9	10
1.	L R										0	1	2	3	4	5	6	7	8	9	10
2.	L R										0	1	2	3	4	5	6	7	8	9	10
3.	L R										0	1	2	3	4	5	6	7	8	9	10
4.	L R										0	1	2	3	4	5	6	7	8	9	10