Welcome!

Charlotte Chiropractic and Rehab

NEW PATIENT HEALTH HISTORY

Date: _____

Patient Data

First Name _____ Last Name _____ Email _____

- Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

Mailing Address

Address _____ City _____ State _____ Zip _____
Phone (cell) _____ (home) _____ (work) _____
Preferred Phone: Cell Home Work Birth Date ____/____/____ Age _____
Gender: Male Female Marital Status: _____
Name of significant other: _____
How did you find us: Friend Insurance Plan Website Google
Yelp Facebook Instagram Other_____

Employer Data

Employer _____ Your Occupation _____
Brief description:
_____
Your typical day: Sit at computer most of day Light manual labor Heavy manual labor Repeated motion

Emergency Contact Information

Name _____ Relationship to patient _____
Contact phone: _____ Alternative phone_____

Payment Information

Who is responsible for you bill? Self Spouse Health Insurance Employer Other_____
Health Insurance Company _____ ID # _____ Group # _____

If Auto Accident or Worker's Compensation

Name of Insurance Company _____ Claim number _____
Adjuster's name _____ ___ Adjusters phone _____
Attorney's name _____ Attorney's phone _____

Patient Name: _____ **Date** _____

Medical History

Medical conditions (circle all that apply to you):

Arthritis Cancer Diabetes Heart Disease Hypertension Psychiatric illness Stroke High Cholesterol NONE

Other_____

What medications are you taking?_____

What vitamins, mineral, herbs do you take? _____

What allergies do you have? _____

What previous surgeries have you had? _____

Previous accidents, slip/falls, sports injuries, fractures? _____

_____

Family History (M=Mother, F=Father, GM=Grandmother, GF=Grandfather)

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

Habits	None	Light	Moderate	Severe	Habits	None	Light	Moderate	Severe
Alcohol	____	____	____	____	Tobacco	____	____	____	____
Coffee	____	____	____	____	Drugs	____	____	____	____

Review of Systems

Musculoskeletal	No	Past	Present
Neck Pain			
Neck Stiffness			
Head heavy			
Back Pain			
Muscle spasm			
Gout			
Genitourinary	No	Past	Present
Kidney disease			
Kidney stones			
Burning urination			
Frequent urination			
Psychiatric	No	Past	Present
Depression			
Anxiety			
Stress / Tension			
Respiratory	No	Past	Present
Chest pain			
Asthma			
Tuberculosis			
Emphysema			

Neurologic	No	Past	Present
Pins/Needles in arms			
Pins/Needles in legs			
Numbness in fingers			
Numbness in toes			
Headaches			
Pinched Nerves			
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Parkinson's			
Carpal Tunnel			
Vertigo			
Cardiovascular	No	Past	Present
Poor circulation			
Hypertension			
Aortic aneurism			
Heart disease			
Heart attack			
High cholesterol			
Pace maker			

Immunologic	No	Past	Present
Fever			
Immune disorder			
HIV / AIDS			
Ear, Nose, Throat	No	Past	Present
Dizziness			
Ringing in ears			
Difficulty swallowing			
Jaw pain			
Sinus infections			
Hearing loss			
Gastrointestinal	No	Past	Present
Gall bladder			
Constipation			
Diarrhea			
Ulcers			
Liver issues			
Endocrine	No	Past	Present
Thyroid			
Diabetes			

Patient Name: _____ **Date** _____

Chief Complaint(s)

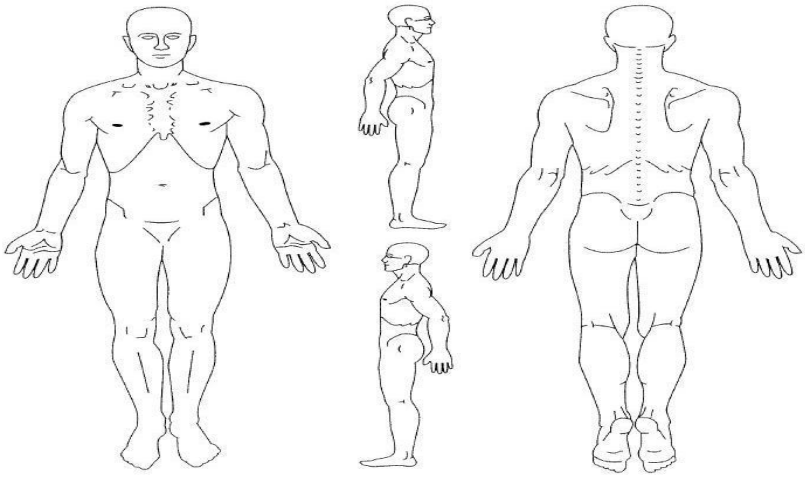
Describe your symptoms in order of severity, with worse symptom being #1:

1. _____

2. _____

3. _____

Indicate on the body diagram where you are experiencing the following symptoms, using an (X) or circling the area:



When did your symptoms begin? _____

How did your symptoms begin?_____

What describes the nature of your symptoms? Sharp Shooting Stabbing Dull ache Burning

Numb/Tingling Other_____

Are your symptoms? Getting better Staying the same Getting worse

Average Pain Intensity: (a range is ok)

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

How often do you experience your symptoms?

Constantly	Frequently	Occasional	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What makes it better? Sitting Standing Lying Bending Twisting Lifting

Other_____

What makes it worse? Sitting Standing Lying Bending Twisting Lifting

Other_____

What have you done for it so far? _____

Have you experienced this problem or similar problem before? Yes No

If yes, please explain _____

Are you pregnant? Yes No N/A

Patient Name: _____ **Date** _____

HIPPA PRIVACY PRACTICES

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

Print Patient's Name _____

Patient/Parent/Guardian Signature: _____ Date _____

FINANCIAL POLICY

I understand and agree that health and accident insurance policies are an agreement between and insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient/Parent/Guardian Signature: _____ Date _____

CONSENT TO TREAT MINOR

I _____ hereby authorize Dr. Derek Maul and whomever he may designate as chiropractic assistants to administer chiropractic care as deemed necessary to my son/daughter, _____ (minor's name).

Patient/Parent/Guardian Signature: _____ Date _____

EMAIL NEWSLETTER

Occasionally we send email blasts to announce changes in office hours, special offers and informative news. If you would like to receive these emails, please sign below. You can unsubscribe at any time.

Patient/Parent/Guardian Signature: _____ Date _____

NOTIFICATION POLICY

I, hereby consent to have my physician, Dr. Derek Maul, and other staff at Charlotte Chiropractic and Rehab to communicate with me by email, phone, and standard SMS/ text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and/or viewed by a third party.

I give my permission to have both appointments reminders and other private health information provided to me via phone, email, and standard SMS/text messaging.

Print Patient's Name _____

Patient/Parent/Guardian Signature: _____ Date _____