

# \_\_\_\_\_  
Date \_\_\_\_\_

## HOLLY SPRINGS CHIROPRACTIC CONFIDENTIAL PATIENT INFORMATION

**Welcome to Holly Springs Chiropractic, P.A.!** Please complete the following forms **COMPLETELY** and **ACCURATELY**. Your answers will help determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. If you need help, please ask us.

This information will be held in the strictest confidence.

How did you hear about our office? \_\_\_\_\_

### Patient Data:

Name: Mr. Mrs. Miss. Ms. \_\_\_\_\_ Prefer to be called: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email Address \_\_\_\_\_  
SS# \_\_\_\_\_ Drivers License # \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_  
Marital Status: Single/Married/Divorced/Widowed Spouse's Name: \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer \_\_\_\_\_  
In case of Emergency \_\_\_\_\_ Phone# \_\_\_\_\_

### Present Compliant:

What are your symptoms? \_\_\_\_\_

On a scale of 0 (no pain) to 10 (worst pain) please rate how you feel today: 0 1 2 3 4 5 6 7 8 9 10  
How long have you had this condition? \_\_\_\_\_ Years \_\_\_\_\_ Months Have you had similar symptoms in the past? Y/N  
If yes, please explain \_\_\_\_\_  
How often does it occur? \_\_\_\_\_ Occasionally \_\_\_\_\_ Frequently \_\_\_\_\_ Constantly  
Since your symptoms began, are you getting: Better \_\_\_\_\_ Worse \_\_\_\_\_ No Change \_\_\_\_\_  
Does your condition interfere with your: \_\_\_\_\_ Work \_\_\_\_\_ Sleep \_\_\_\_\_ Daily Routine \_\_\_\_\_ Other \_\_\_\_\_  
What were you doing when you first noticed your symptoms? \_\_\_\_\_  
What makes you feel worse? \_\_\_\_\_  
What have you done to ease the discomfort? \_\_\_\_\_  
What other doctors have you seen for this condition? \_\_\_\_\_

### History:

Have you ever been to a Chiropractor? Y/N If so, where? \_\_\_\_\_  
Are you taking any medications? Y/N If so, which? \_\_\_\_\_  
Have you ever been hospitalized? Y/N Why? \_\_\_\_\_  
List any surgeries and dates: \_\_\_\_\_  
Who is your family physician? \_\_\_\_\_ Phone # \_\_\_\_\_  
Date last seen \_\_\_\_\_ Reason \_\_\_\_\_  
Have you ever been in an automobile accident? Y/N Please describe: \_\_\_\_\_  
Any other traumas? \_\_\_\_\_ List any allergies \_\_\_\_\_  
List any known family illnesses \_\_\_\_\_  
Do you smoke? Y/N How much? \_\_\_\_\_ Do you drink alcohol? Y/N How much? \_\_\_\_\_  
Do you take any vitamin supplements? Y/N Which? \_\_\_\_\_ Do you wear heel lifts or orthotics? Y/N  
What type of physical activity do you do? \_\_\_\_\_ How often? \_\_\_\_\_  
Is there anything else you would like us to know? \_\_\_\_\_

# HOLLY SPRINGS CHIROPRACTIC MEDICAL HISTORY

**CHECK ANY OF THE FOLLOWING DISEASE YOU HAVE HAD:**

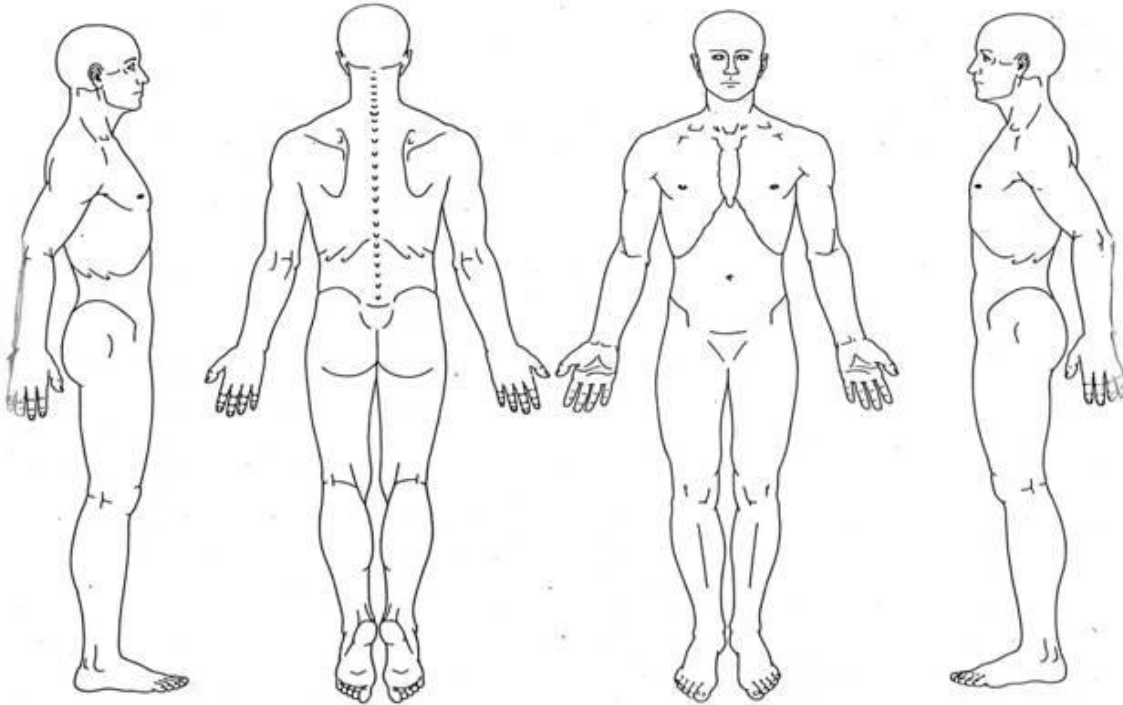
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Pneumonia<br><input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Polio<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Whooping Cough<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Measles | <input type="checkbox"/> Mumps<br><input type="checkbox"/> Small Pox<br><input type="checkbox"/> Chicken Pox<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Thyroid | <input type="checkbox"/> Influenza<br><input type="checkbox"/> Pleurisy<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Mental Disorders<br><input type="checkbox"/> Lumbago<br><input type="checkbox"/> Eczema |
|---|--|--|

**HAVE YOU EXPERIENCED ANY OF THE FOLLOWING WITHIN THE PAST 6 MONTHS:**

<p><b><u>GENERAL</u></b></p> <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Fatigue <input type="checkbox"/> Nervousness <input type="checkbox"/> Weight Loss or Gain <input type="checkbox"/> Allergies <input type="checkbox"/> Bleeding Problem	<p><b><u>SKIN</u></b></p> <input type="checkbox"/> Itching <input type="checkbox"/> Bruising Easily <input type="checkbox"/> Change in Mole(s) <input type="checkbox"/> Psoriasis	<p><b><u>NEUROLOGIC</u></b></p> <input type="checkbox"/> Weakness <input type="checkbox"/> Twitching <input type="checkbox"/> Tremors <input type="checkbox"/> Headache <input type="checkbox"/> Fainting <input type="checkbox"/> Dizziness <input type="checkbox"/> Convulsions <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Arm/Leg Pain
<p><b><u>EYE/EAR/NOSE/THROAT</u></b></p> <input type="checkbox"/> Poor Vision <input type="checkbox"/> Pain in Eye(s) <input type="checkbox"/> Deafness/Difficulty Hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Nose Problems <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Hoarseness	<p><b><u>CARDIOVASCULAR</u></b></p> <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Pain over Heart <input type="checkbox"/> Previous Heart Trouble <input type="checkbox"/> Ankle Swelling <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Stroke	<p><b><u>MUSCULOSKELETAL</u></b></p> <input type="checkbox"/> Neck Stiffness/Pain <input type="checkbox"/> Pain Between Shoulders <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Painful Joints <input type="checkbox"/> Muscle Aches/Soreness <input type="checkbox"/> Spinal Curvature
<p><b><u>GASTROINTESTINAL</u></b></p> <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Poor Digestion <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Frequent Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Pain over Abdomen <input type="checkbox"/> Ulcer <input type="checkbox"/> Black or Bloody Stools <input type="checkbox"/> Liver Problems <input type="checkbox"/> Gall Bladder Problems <input type="checkbox"/> Hernia <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Appendicitis	<p><b><u>GENITOURINARY</u></b></p> <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Painful Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Urinary Infection <input type="checkbox"/> Inability to Control Urination <input type="checkbox"/> Difficulty Starting Urine Flow <input type="checkbox"/> Get up ___ Times per Night to Urinate <input type="checkbox"/> Breast Lump or Pain <input type="checkbox"/> Venereal Infection <input type="checkbox"/> Sexual Difficulties	<p><b><u>RESPIRATORY</u></b></p> <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Spitting Phlegm <input type="checkbox"/> Spitting Blood <input type="checkbox"/> Wheezing/Asthma
<p><b><u>MEN ONLY</u></b></p> <input type="checkbox"/> Testicular Swelling/Pain <input type="checkbox"/> Prostate Problems	<p><b><u>Women Only</u></b></p> <input type="checkbox"/> Painful Periods <input type="checkbox"/> Excessive Flow <input type="checkbox"/> Irregular Cycles <input type="checkbox"/> Vaginal Burning/Itching <input type="checkbox"/> Hot Flashes  <hr style="width: 50%; margin-left: 0;"/> Date of Last Period	<p><b><u>FAMILY HISTORY</u></b></p> Include information on brothers, sisters, parents, & grandparents. DO NOT INCLUDE YOURSELF. <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease/Goiter <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Kidney Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Muscle, Bone, or Nerve Disease

# HOLLY SPRINGS CHIROPRACTIC MEDICAL HISTORY

Please Indicate the Area of Complaint (If Applicable):



Is this Pain/Sensation: (Please Circle)

**SHARP**

**STABBING**

**DULL**

**ACHY**

**THROBBING**

**TINGLING**

**STIFF**

**BURNING**

**NUMB**

# **Holly Springs Chiropractic**

## **Assignment of Proceeds, Lien and Authorization**

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("condition") to pay directly and exclusively in the name of Holly Springs Chiropractic PA ("HSC" or "Office") such sums as may be owing to HSC for charges incurred by me at the office relating to my condition ("charges"), with such payments to be made exclusively in the name of Holly Springs Chiropractic , PA. I further grant a lien to HSC with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document (herein, "Assignment and Lien"), "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, 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, and any other benefits or proceeds payable to me for the purposes stated herein.

In the event that I retain one or more attorneys to represent me in this matter who are not located in North Carolina, 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 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 Assignment and Lien. I further authorize and direct all payers to release to HSC any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this Office to file a copy of this Assignment and Lien, together with any applicably charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize HSC 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 HSC 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 hereby authorize and direct my attorney to disclose upon the request of HSC, any settlement amounts or any offers made on my case from any potential payers.

I understand that I remain personally responsible for the total amounts due HSC 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 HSC 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 HSC 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.

Patient Name (please print) \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Name of Custodial Parent or Legal Guardian (please print) \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_