Holly Springs Chiropractic

Patient Health History

Today's Date [/ /] **Signature of Patient** ____________________

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name____________________ **Nick Name**____________________

Last Name ____________________ **Middle Name** ____________________**Suffix** __________

Address 1 ____________________

Address 2 ____________________

City____________________ **State**__________ **Zip Code** __________

Primary Phone ____________________**Secondary Phone** ____________________

Mobile Phone ____________________

Home email ____________________ **Work Email** ____________________

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email ❑Text Msg

Date of Birth [/ /] **Age** ________ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **Spouse Name** ____________________

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Occupation ____________________

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑Samoan ❑ Guamanian or Chamorro ❑Other__________ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Continued …

Verification Question *(choose only one question by checking the question box, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: ______________________________

Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No interest *Very Interested*

Current medications, including frequency and dosage if known.
If there are no current medications, check here: ❑

	Dose		Dose
1)		**5)**	
2)		**6)**	
3)		**7)**	
4)		**8)**	

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) ______________________ **3)** ______________________

2) ______________________ **4)** ______________________

Briefly list your main health problems: ______________________________

____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: ______________

____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: ______________________________

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff: Temp: ____________ Heart Rate: ________________

Height: ________inches **Weight:** ____________ pounds **BP:** ________ / ________

Present Complaint:

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? _________________ 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/School _______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?____

Have you ever been to a Chiropractor? Y/N If so, where?_______________________________________

What type of physical activity do you do?_______________________________How often? _____________

Is there anything else you would like us to know?____

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 List any dates:______________________________

Any other traumas?____

Emergency Contact: ______________________________ Phone Number(s) _____________________________

How did you hear about us? ____

MEDICAL HISTORY

CHECK ANY OF THE FOLLOWING DISEASE/CONDITION YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

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

GENERAL

- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Loss of Sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Weight Loss or Gain
- ☐ Allergies
- ☐ Bleeding Problem

SKIN

- ☐ Itching
- ☐ Bruising Easily
- ☐ Change in Mole(s)
- ☐ Psoriasis

NEUROLOGIC

- ☐ Weakness
- ☐ Twitching
- ☐ Tremors
- ☐ Headache
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Numbness/Tingling
- ☐ Arm/Leg Pain

EYE/EAR/NOSE/THROAT

- ☐ Poor Vision
- ☐ Pain in Eye(s)
- ☐ Deafness/Difficulty Hearing
- ☐ Nosebleeds
- ☐ Nose Problems
- ☐ Sinus Trouble
- ☐ Hoarseness

CARDIOVASCULAR

- ☐ Irregular Heartbeat
- ☐ High Blood Pressure
- ☐ Pain over Heart
- ☐ Previous Heart Trouble
- ☐ Ankle Swelling
- ☐ Varicose Veins
- ☐ Rheumatic Fever
- ☐ Stroke

MUSCULOSKELETAL

- ☐ Neck Stiffness/Pain
- ☐ Pain Between Shoulders
- ☐ Low Back Pain
- ☐ Swollen Joints
- ☐ Painful Joints
- ☐ Muscle Aches/Soreness
- ☐ Spinal Curvature
- ☐ Fibromyalgia

GASTROINTESTINAL

- ☐ Poor Appetite
- ☐ Poor Digestion
- ☐ Difficulty Swallowing
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Pain over Abdomen
- ☐ Ulcer
- ☐ Black or Bloody Stools
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Hernia
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Appendicitis

GENITOURINARY

- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Kidney Disease
- ☐ Urinary Infection
- ☐ Inability to Control Urination
- ☐ Difficulty Starting Urine Flow
- ☐ Get up ___ Times per Night to Urinate
- ☐ Breast Lump or Pain
- ☐ Venereal Infection
- ☐ Sexual Difficulties

RESPIRATORY

- ☐ Difficulty Breathing
- ☐ Chronic Cough
- ☐ Spitting Phlegm
- ☐ Spitting Blood
- ☐ Wheezing/Asthma

MEN ONLY

- ☐ Testicular Swelling/Pain
- ☐ Prostate Problems

Women Only

- ☐ Painful Periods
- ☐ Excessive Flow
- ☐ Irregular Cycles
- ☐ Vaginal Burning/Itching
- ☐ Hot Flashes

____
Date of Last Period

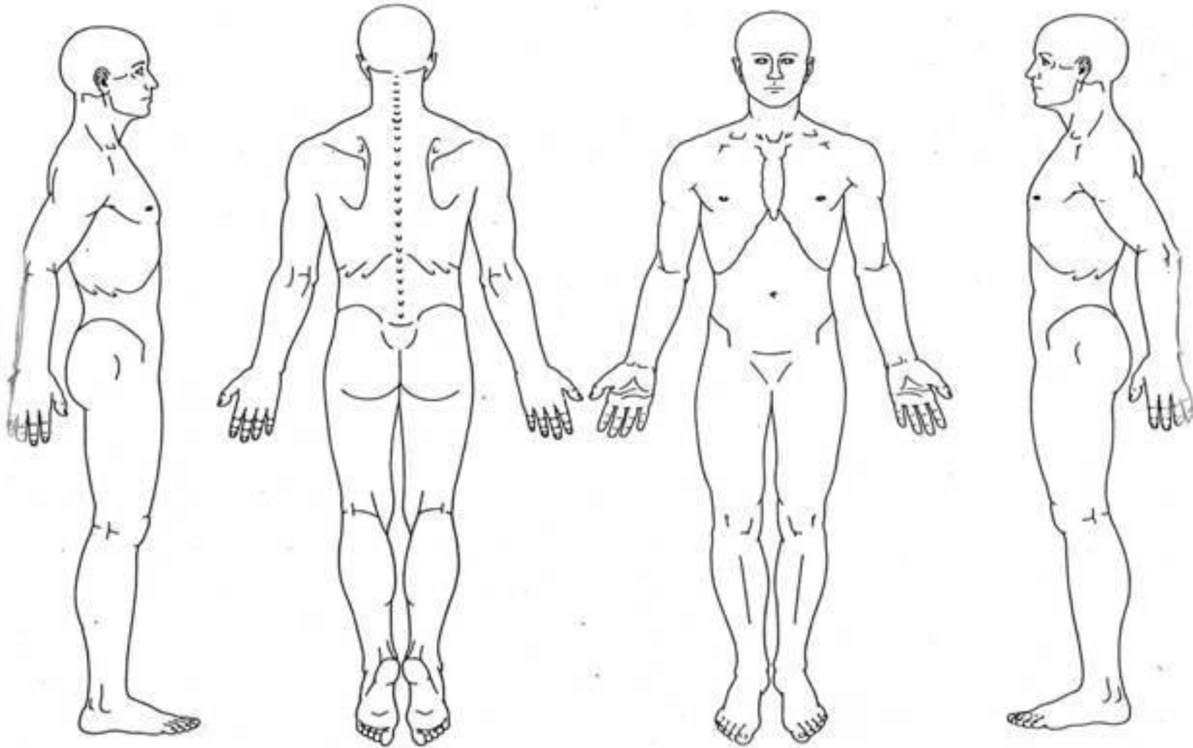
FAMILY HISTORY

Include information on brothers, sisters, parents, & grandparents. DO NOT INCLUDE YOURSELF.

- ☐ Diabetes
- ☐ Thyroid Disease/Goiter
- ☐ Tuberculosis
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Cancer
- ☐ Muscle, Bone, or Nerve Disease

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 ____