152 Capcom Avenue Suite 104 Wake Forest, NC 27587
919.554.8989

CASE NO. __________

Please fill out the following form in as much detail as possible.
Please Print

Date:_______________

Name____
Address____

City____ State_________ Zip_______________

Home Phone_______________ Office Phone _______________ Cell Phone _______________

Preferred Phone: H___ O___ C___ Email Address______________________________________

Age ________ Date of Birth _____________ Occupation ______________________ Sex (M) (F)

Referred by ____

Employer _______________________________ Address _________________________________

Married ____ S____ W____ D____ Children ____ Name of Spouse _______________________

Is any member of you family being treated in this office? _______________________________

Have you ever had chiropractic care before? ____

For what problem? ____

Were the results satisfactory? Yes ______ No _______ N/A _________

Major Complaints and Symptoms – please be as specific as you can. Ask the doctor or nurse for help if you need assistance in filling out this section. ____________________________________

____

____

____

____

How do you believe your problem/pain began? _______________________________________

____

____

____

____

____

When did you first notice the problem/pain? ____

152 Capcom Avenue Suite 104 Wake Forest, NC 27587
919.554.8989

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter **N** if you have these conditions now (within the past 12 months) or **P** if you ever had these conditions in the past.

	Now **N**	Past **P**
Headaches [____ Frequency]	____	____
Neck Pain	____	____
Stiff Neck	____	____
Sleeping Problems	____	____
Back Pain	____	____
Nervousness	____	____
Tension	____	____
Irritability	____	____
Chest Pain	____	____
Dizziness	____	____
Shoulder/Neck/Arm Pain	____	____
Pins & Needles in Arms	____	____
Pins & Needles in Legs	____	____
Numbness in Fingers	____	____
Numbness in Toes	____	____
High Blood Pressure	____	____
Difficulty Urinating	____	____
Allergies	____	____
Weakness in Arms	____	____
Weakness in Legs	____	____
Shortness of Breath	____	____
Fatigue	____	____
Depression	____	____
Lights Bother Eyes	____	____
Loss of Memory	____	____
Ears Ring	____	____
Face Flushed	____	____
Buzzing in Ears	____	____

	Now **N**	Past **P**
Loss of Balance	____	____
Fainting	____	____
Loss of Smell	____	____
Loss of Taste	____	____
Diarrhea	____	____
Feet Cold	____	____
Hands Cold	____	____
Arthritis	____	____
Muscle Spasms	____	____
Frequent Colds	____	____
Stomach Upset	____	____
Constipation	____	____
Cold Sweats	____	____
Fever	____	____
Sinus Problems	____	____
Diabetes	____	____
Hemorrhoids	____	____
Leg Cramps	____	____
Colitis	____	____
Gall Bladder	____	____
Indigestion	____	____
Belching	____	____
Vomiting	____	____
Shoulder Pain	____	____
Swelling Joints	____	____
Knee Pain	____	____
Hayfever	____	____
Menstrual Difficulties	____	____

I understand and agree that health and accidental insurance policies are an agreement between the insurance carrier and myself, and that all services rendered me are charges 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 me will be immediately due and payable.

PATIENT SIGNATURE: ____

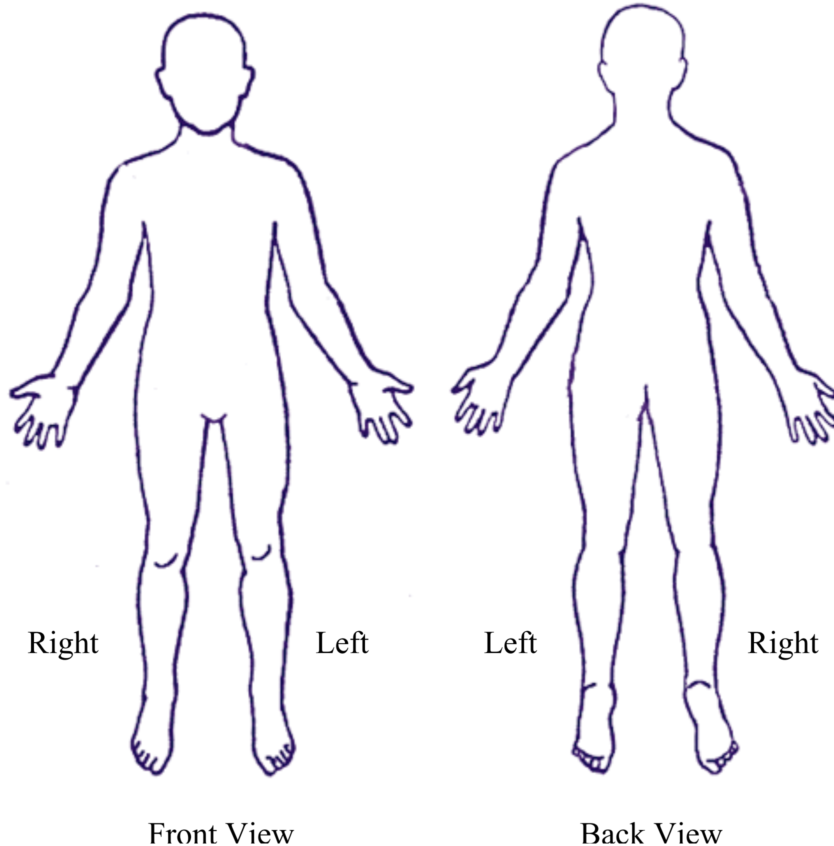
152 Capcom Avenue Suite 104 Wake Forest, NC 27587
919.554.8989

Mark the areas on this body where you feel the described sensations.
Use appropriate symbols. Mark areas where pain radiates.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/ / / / /
- - - - -	00000	xxxxx	*****	/ / / / /
- - - - -	00000	xxxxx	*****	/ / / / /

Please mark on the pain scale from Zero to 10 the pain you feel with this condition.
10 being the worst pain you have felt with this condition

Pain Chart



Neck-Shoulder-Arm Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_________________________)
0 10
no pain severe pain

Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_________________________)
0 10
no pain severe pain

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_________________________)
0 10
no pain severe pain

Signature:____________________________________ Date:______________________

152 Capcom Avenue Suite 104 Wake Forest, NC 27587
919.554.8989

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain you informed consent before starting treatment.

I ____________________________________, of ___________________________(city) do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms of dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies, like weak bones from osteoporosis, may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in a ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor, and such other persons of the doctor's choosing.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

152 Capcom Avenue Suite 104 Wake Forest, NC 27587
919.554.8989

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continues indefinitely. Some medication may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but not corrective of injured nerve and joint issues.

Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Nontreatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

____Signature of Patient

____Date & Time

--Office Use Only--

Patient Status at Time of Informed Consent Process

Based on my personal observations, medical history and direct conversation with the patient I conclude that throughout the consent process the patient was:

[ ] Of legal age
[ ] Coherent and lucid
[ ] Consent given thru legal guardian

Name: __________________________ Relationship: _________________________

I certify that the above accurately describes the above name patient's status during the informed consent process on _______________________________________.

Signature of Doctor:________________________________ Date: ___________________

152 Capcom Avenue Suite 104 Wake Forest, NC 27587
919.554.8989

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient,
And "Chiropractor" refers to Atlas Family Chiropractic.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my heath care bills or to conduct health care operations of Chiropractor. I understand that analysis diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at Atlas Family Chiropractic. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Note of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Printed Name: ____

Signature of Patient: ______________________________________ Date: _________________