CAROLINALIFE Chiropractic

ABOUT THE PATIENT

Confidential

2700 Woodruff Rd. L. Simpsonville, SC 29681

Name _____ Today's Date_____ Birthdate _____ Age_____ Weight _____ Gender ❑ M ❑ F

Address _____ City _____ State _____ Zip_____

Phone _____ Work Phone_____ Email _____

Marital Status: S M D W Other Spouse Name _____ Number of Children _____Ages _____

Occupation _____ How Long? _____ Employer _____ Insurance Y/N_____

Emergency Contact _____Ph _____ Email _____

How did you hear about us? _____Have you had chiropractic care before? ❑ No ❑ Yes When? _____

Name of Primary Care Medical Doctor / Referring Physician_____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Carolina Life Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- I authorize my (or my child's) picture/video/testimonial to be used in printed company material and social media posts. ❑ Yes ❑ No
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.
- I prefer to be contacted by ❑ Email ❑ Text ❑ Phone Call _____
- Person responsible for this account if other than the patient? _____

Name: _____ Signature: _____ Date _____

Patient / Parent (I verify all the information provided is true)

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ When did it start? _____ Had it in the past? Y / N When? _____ How Often? _____

Worse in the: Morning / Midday / EOD / Night ❑ Constant ❑ Intermittent ❑ Daily ❑ Weekly ❑ Monthly

Is it: ❑ Achy ❑ Burning ❑ Deep / Pressure ❑ Dull ❑ Numb / Tingle ❑ Sharp / Stabbing ❑ Tight / Stiff ❑ Weak ❑ Other ❑ Travels

Rate It:: 1-10 (10 = worst) 1 2 3 4 5 6 7 8 9 10 Is it: Better / Worse / Same

2. _____ When did it start? _____ Had it in the past? Y / N When? _____ How Often? _____

Worse in the: Morning / Midday / EOD / Night ❑ Constant ❑ Intermittent ❑ Daily ❑ Weekly ❑ Monthly

Is it: ❑ Achy ❑ Burning ❑ Deep / Pressure ❑ Dull ❑ Numb / Tingle ❑ Sharp / Stabbing ❑ Tight / Stiff ❑ Weak ❑ Other ❑ Travels

Rate It:: 1-10 (10 = worst) 1 2 3 4 5 6 7 8 9 10 Is it: Better / Worse / Same

3. _____ When did it start? _____ Had it in the past? Y / N When? _____ How Often? _____

Worse in the: Morning / Midday / EOD / Night ❑ Constant ❑ Intermittent ❑ Daily ❑ Weekly ❑ Monthly

Is it: ❑ Achy ❑ Burning ❑ Deep / Pressure ❑ Dull ❑ Numb / Tingle ❑ Sharp / Stabbing ❑ Tight / Stiff ❑ Weak ❑ Other ❑ Travels

Rate It:: 1-10 (10 = worst) 1 2 3 4 5 6 7 8 9 10 Is it: Better / Worse / Same

4. Does your condition affect: ❑ Bathing ❑ Bending ❑ Dressing ❑ Driving ❑ Exercising ❑ Getting up ❑ Household chores ❑ Lift/Carry ❑ Laying Down ❑ Sleep ❑ Sitting ❑ Standing ❑ Walking ❑ Working ❑ Other _____

5. What makes it better? _____

6. What makes it worse? _____

7. What Doctor's have you seen for this?_____

8. Received treatment _____

9. Results: _____

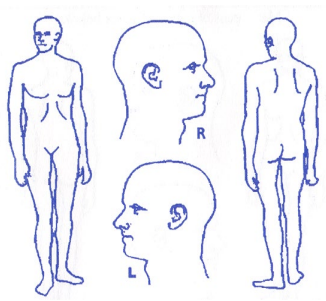
10. Is this the result of an Auto accident Y / N . Work Injury Y / N _____

11. Have you missed School or Work Y / N

NOTES: _____

_____

Are you pregnant?



Please mark all areas of concern.