

Taylor Chiropractic Clinic
414 Dabney Drive
Henderson, NC 27536
Phone (252) 430-8000
Fax (252) 430-8200

CONFIDENTIAL HEALTH INFORMATION
QUESTIONNAIRE

This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need assistance, please ask our receptionist, and we will be happy to have someone assist you.

Your name: _____ Date: _____

Address: _____

City: _____ State _____ Zip Code _____

Home Phone # _____ Cell _____

Age: _____ Date of Birth _____ SS# _____

Email address _____ Drivers License # _____

Marital Status: ___ M ___ S ___ D ___ W

Your Occupation: _____ Employed By: _____

Phone # _____ Address: _____

Is your visit due to an auto accident? ___ Yes ___ No

Are you a Medicare patient? ___ Yes ___ No Medicare # _____

Your spouse's name: _____

Spouse's Employer: _____ Spouse's work # _____

Name of person to contact in case of emergency: _____

Their home and work phone # _____

Name of closest living relative not living with you: _____

Their phone # _____

Who referred you to our office so we may thank them: _____

Referring physician: _____

In order to determine if care can be of benefit to you, this office will extend the courtesy of an initial consultation without charge. If the doctor might be able to help you with your condition, are you interested in seeking care? _____ Yes _____ Unsure

**THERE WILL BE NO CHARGED SERVICES WITHOUT YOUR INFORMED
CONSENT**

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

Patient's
Signature: _____ Date _____

Parent or Guardian: _____

Signature: _____ Date _____

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INFORMED CONSENT FOR EXAMINATION AND
TREATMENT

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctor of chiropractic and/or licensed physical therapist who may be employed or engaged in practice in the clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strains/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual cycle: _____

Patient's Name (print)

Patient's Signature

Date

Witness

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NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosure for the purpose of treatment, payment, or practice operations will be made only after obtaining your consent. You may also request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer to the medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for the photocopying, postage, and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations to our Office Manager.

Name _____ Phone _____

The effective date of this Notice of Information Practice is _____.

Thank you

Insurance Coverage Information

Medical Insurance:

Insurance Carrier: _____

Phone No: _____

Policy Holder Name: _____

Policy No: _____ Group No: _____

Workers Compensation Injury:

Employer: _____ Work No: _____

Address: _____ Supervisor: _____

Was accident/injury reported to a supervisor: ___ Yes ___ No If so, date and time _____

Workers Comp Carrier: _____ Policy No: _____

Carriers Phone: _____ Adjuster: _____

Claim No: _____

Auto/Personal Injury:

Do you have "Med Pay" on your auto policy: ___ Yes ___ No Amount _____

Insurance Carrier Name: _____ Phone: _____

Adjuster: _____ Claim No: _____

Third Party Payer: (other involved vehicle insurance)

Third party (person at fault's)

Name: _____ Phone: _____

THEIR Insurance Carrier: _____ Phone: _____

Address: _____

Adjuster: _____ Claim No: _____

Patient

Name: _____ Date: _____

Present Complaints

List any operations that you have had and approximate dates:

1. _____ Date: _____ Dr: _____

2. _____ Date: _____ Dr: _____

3. _____ Date: _____ Dr: _____

Are you allergic to any medications? Please

list: _____

Are you currently taking any medications? Please

list _____

Do you wear Orthotics (shoe inserts)? ____ yes ____ no

If so, what type? _____

Are you pregnant? ____ yes ____ no If so, due date: _____

Do you: Smoke ____ yes ____ no Amount per day: _____

Drink ____ yes ____ no ____ light ____ medium ____ heavy

Exercise ____ never ____ sometimes ____ frequently ____ regularly

Describe your diet:

How many meals a day do you eat? _____

How much water do you drink? _____

How much caffeine do you consume a day? _____

Do you take a multi-vitamin? _____

Does anyone in your family have a similar health related problem? ____ yes ____ no

Who: _____ What condition? _____

Care they are receiving: _____

Is it helping? ____ yes ____ no

May we contact them regarding their condition? ____ yes ____ no

Patient Name: _____ Date: _____

Present Complaints cont.

Please circle the appropriate ones:

Headache	Feet/hands cold	Head seems heavy	Pin and needles in arms
Mental dullness	Depression	Confusion	Right/Left
Loss of memory	Pins/Needles in Arms	Constipation	Pin and needles in hands
Dizzy	Rib pain	Unbalanced	Right/Left
Neck Pain	Neck Stiffness	Chest pain	Pin and needles in legs
Fainting	Shortness of breath	Ears ringing/buzzing	Right/left
Upper back pain	Upper back stiffness	Midback pain	Midback stiffness
Lower back pain	Lower back stiffness	Blurred vision	Double vision
Neck restriction	Eye strain/pain	Loss of taste	Loss of smell
Nervousness	Fear	Irritability	Tension

Difficulty in: ___ Standing ___ Sitting ___ Bending ___ Walking

Pain radiation to the ___ Right arm ___ right leg ___ Left arm ___ left leg

Cannot lift: ___ light ___ moderate ___ heavy ___ repetitive

Pain radiating to: ___ neck ___ base of skull ___ ribs ___ shoulders ___ arms

Pain in the: ___ foot ___ ankle ___ knee ___ hip ___ heel spurs

Other: _____

Since the time this (these) complaint(s) began, what, if anything have you tried that **DID NOT** work? _____

Has the problem interrupted your sleep? ___ yes ___ no How: _____

Does anyone in your family have the same or similar condition? ___ yes ___ no

Who: _____

List any doctors or therapists that you have seen for this complaint?

1. _____ Specialty: _____

2. _____ Specialty: _____

3. _____ Specialty: _____

Relevant medical history: Please circle the conditions you have had or had previously

Arthritis	Epilepsy	Muscular Dystrophy
Asthma	Fibromyalgia	Neck pain or spasms
Anemia	Hand or wrist pain	Neuritis
Back pain or spasm	Headaches	Numbness
Cancer	Heart problems	Polio
Concussion	Hepatitis	Rheumatic Fever
Convulsion	High blood pressure	Sinus trouble
Diabetes	HIV	Sciatica
Digestion problems	Measles	TB
Dizziness	Multiple sclerosis	Venereal disease

Patient Name: _____ Date: _____

Authorization (to release information) & Assignment (of benefits)

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the changes made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit.

Signature: _____ DATE: _____

With your permission, we may submit a report of your present condition to your primary care doctor. Do we have your permission? _____yes _____no

Name of primary care doctor: _____ Phone: _____

Address, City, State: _____