Acct # _____ Provider # _____ CA _____

Patient Name: _____ **Today's Date:** _____

Date of Birth:_____

Address: _____ **Apt#:** _____
City: _____ **State:** _____ **Zip:** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Email Address _____

What do you prefer to be called? _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Decline to Answer

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black of African American
☐ Native Hawaiian or Pacific Islander ☐ White/Caucasian ☐ Decline to Answer

Preferred Language: ☐ English ☐ Spanish ☐ Other (Please Specifiy: _____)

Smoking Status: ☐ Never ☐ Former Smoker ☐ Current Every Day Smoker ☐ Current Some Day Smoker

FEMALE PATIENTS ONLY: Are you currently pregnant? ☐ No ☐ Yes (Due Date: ___/___/___)

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Retired ☐ Student (Full/Part Time)

Employer's Name: _____ **Occupation:** _____

Employer Address: _____

City: _____ **State:** _____ **Zip:** _____

Spouse's Name: _____ **Spouse's Employer:** _____

Emergency Contact: _____ **Relationship:** _____
Phone Number: _____

Family Physician (MD): _____ **Practice Name:** _____ **Phone:** _____

Who referred you to our office? We'd like to thank them! _____

Have you ever been to a chiropractor before? ☐ Yes ☐ No (If yes, Who/When: _____)

Chief Complaint: _____ **When did it begin:** _____

Is this visit the result of an injury? ☐ No ☐ Yes If yes, please check one below:

☐ Auto Accident (___/___/___) ☐ Work Injury (___/___/___) ☐ Other Injury (___/___/___)

Please Explain: _____

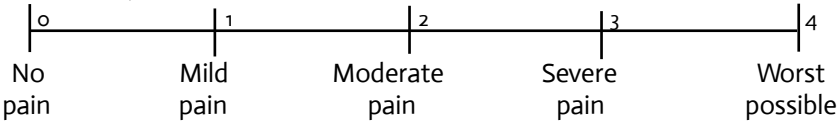
CHARLOTTE CHIROPRACTIC CENTER PLLC

Functional Rating Index

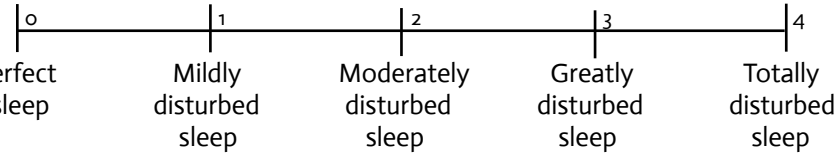
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

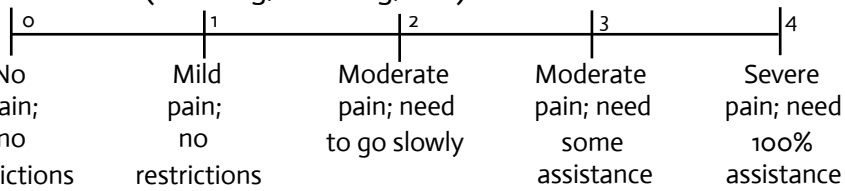
1. Pain Intensity



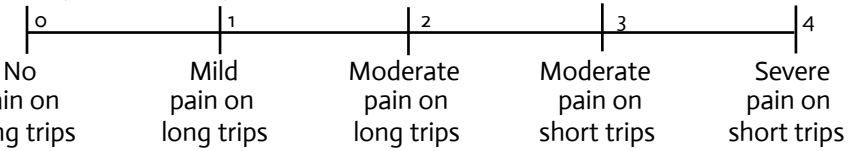
2. Sleeping



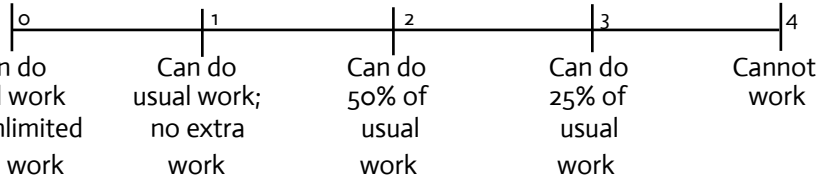
3. Personal Care (washing, dressing, etc.)



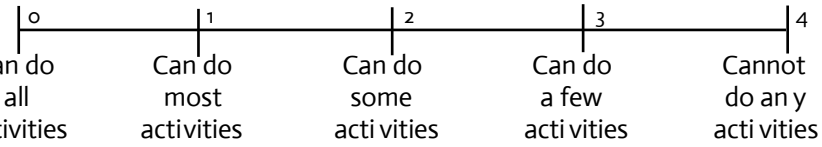
4. Travel (driving, etc.)



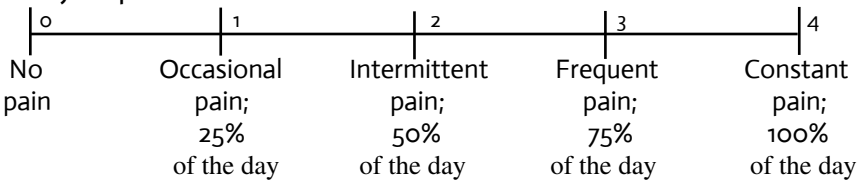
5. Work



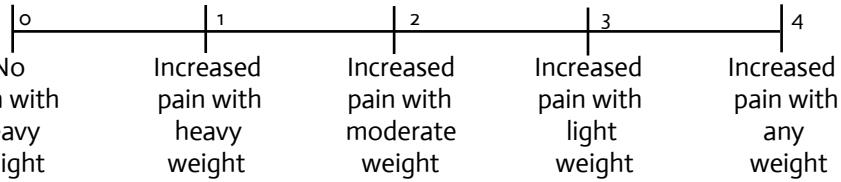
6. Recreation



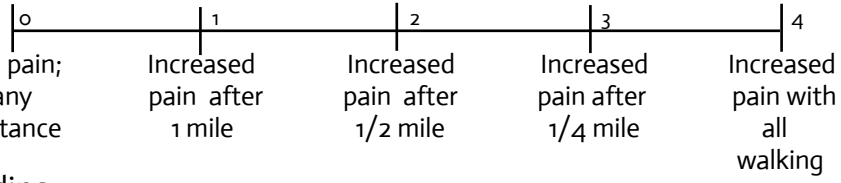
7. Frequency of pain



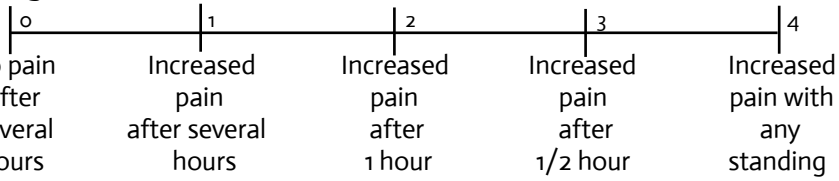
8. Lifting



9. Walking



10. Standing



Name _____ ID#/SS# _____ Plan ID _____ Total Score _____

PRINTED

_____

Signature

_____

Date

Informed Consent

**** Please read this entire document prior to signing it. It is very important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.****

The nature of the chiropractic adjustment The primary treatment used at Charlotte Chiropractic Center, PLLC is spinal manipulative therapy. We will use that procedure to treat you. We may use hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment As a part of the analysis, examination and treatment, you are consenting to the following core procedures: Spinal manipulative therapy, exercises, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, home instructions, hot/cold therapy, electrical stimulation, radiographic studies, mechanical traction, do's and don'ts for proper spinal hygiene and attendance at spinal care class.

The material risks inherent in chiropractic adjustment As with any healthcare procedure, there are certain complications which may arise during treatment. These complications include but are not limited to: fractures, disc injuries, dislocations, stroke, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform us before treatment begins.

The probability of those risks occurring Any complications associated with chiropractic treatment are generally described as rare. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and Xray. The incidence of stroke is exceedingly rare and is estimated to occur between one in one million and one in five million cervical adjustments.

The availability and nature of other treatment option Other treatment options for your condition may include:

Self – administered, over-the-counter analgesics and rest, massage, acupuncture, medical and prescription drugs such as antiinflammatory, muscle relaxants and pain killers, hospitalization and/or surgery. If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

☐ **I have read or**… ☐ **Someone has read to me**…the above explanation of the chiropractic adjustment and any related treatment. I understand that any health concerns or questions will be discussed with the staff of Charlotte Chiropractic Center, PLLC before treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient (printed) Name _____ **Patient Signature** _____

Date _____ **Charlotte Chiropractic Center, PLLC Witness** _____

If patient is under 18 years of age: I hereby authorize any doctors at Charlotte Chiropractic Center, PLLC, or whoever they may designate as their assistant to administer treatment, including x-rays and examinations, necessary to treat

_____ at Charlotte Chiropractic Center, PLLC in Charlotte, NC. _____

Minor's Name (print) Signature of Parent or Legal Guardian

CHARLOTTE CHIROPRACTIC CENTER PLLC

1341 E. Morehead St, Suite 101
Charlotte, NC 28204
Ph. 704-940-7740

Acknowledgement and Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for at least six years.

_____ _____

Patient Name (Printed) Signature of Patient

_____ _____

Name of Parent/Guardian (Printed) Signature of Parent/Guardian or Patient's Legal Representative

_____

Date

Authorization to Disclose Personal/Private Health Information

Please list the name(s) below of any family members or person(s) you wish to have access to your private health information at our office.

Name (First & Last)	Relationship	Phone Number

This authorization will remain in effect until written notification instructing us otherwise