INTRODUCTION PATIENT CASE HISTORY

Today's Date: ____________

PATIENT INFORMATION

Name: (Last, First MI) ______________________________ **Preferred Name:** ____________

Address: ______________________ **City:** ______________ **State:** ______ **Zip:** ________

Home: ____________ **Mobile:** ____________ **Mobile Carrier:** ____________ **Work:** ____________

Email: ______________________ **Gender:** M / F **Marital Status:** Married / Other / Single

Social Security #: ______________________ **Date of Birth:** ______________________

Student Status: Full Student / Part Student / Non-Student ☐ **Employed** **Employer:** ______________

***Referred By:** ______________________

Ethnicity: Hispanic or Latino / Other **Preferred Language:** ______________________

Race: Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: ______________________ **Primary Care Physician:** ______________________

Home: ____________ **Mobile:** ____________ **Doctor's Phone:** ______________________

Relationship: Child / Parent / Spouse / Other: __________

FINANCIAL INFORMATION

☐ Insurance ☐ Worker's Comp ☐ Self-Pay (Cash) ☐ Personal Injury/Auto ☐ Other (please explain):________

PRIMARY INSURANCE

Name: ______________________

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name: ______________ **Gender:** M / F

Address: ______________________

City: ____________ **State:** _____ **Zip:** _______

Phone: ____________ **Date of Birth:** __________

SECONDARY INSURANCE

Name: ______________________

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name: ______________ **Gender:** M / F

Address: ______________________

City: ____________ **State:** _____ **Zip:** _______

Phone: ____________ **Date of Birth:** __________

Who is responsible for payment? Self / Other - *(Relationship)* ______________________

Other than Self:
Full Name: ______________________ **Phone:** ______________

Address: ______________________ **City:** ______________ **State:** ______ **Zip:** ________

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient No: __________

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PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: ______________________________

Began When? ___/___/___ **Describe how this began:** ______________________________

____

____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: ______________

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)* ______________

<u>*Head*</u> - Base of Skull / Forehead / Sides-Temple R / L / Both <u>*Leg*</u> - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

<u>*Arm*</u> – Across Shoulder / Elbow / Hand-Fingers R / L / Both <u>*Other Area:*</u> ______________

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: ______________

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: ______________

Which daily activities are being affected by this condition? *(Describe)* ______________

<u>For this CURRENT condition, have you:</u>

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: ______ **Where?** ______
- **Had any previous Surgery or Interventions in this area?** *(Describe)* ______________
- **Taken any Medications?** OTC / Prescriptions ______________
- **Had any diagnostic testing?** X-rays / MRI / CT / Other: ______ **When and Where?** ______

Describe any Secondary Complaints: ______________________________

HEALTH HISTORY - *(PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)*

<u>Medications:</u>

Allergies to Medications: ***NONE*** *(List)* ______________

____

Current Medications: ***NONE***

(Already have a list? We can make a copy.) ______________

____

____

____

____

<u>Past Health History:</u> *(Please list any past...)*

Surgeries – Date, Type, and Reason: ***NONE***

____

____

____

____

Major Injuries/Traumas: ***NONE*** ______________

____

____

____

Major Hospitalizations: ***NONE*** ______________

____

____

<u>Family Health History:</u> *(Please mark N/A if not relevant.)*

List *relevant* major health problems of immediate relatives:

____

____

____

Deaths in immediate family: *(Cause and at what Age?)*

____

____

____

<u>Social and Occupational History:</u>

Level of Education Completed: ______________

High School / Some College / College Grad. / Post Grad. / Other

Lifestyle: *(Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)*

____

____

____

____

Habits:

Cigarettes – *(#/day)* ______________

Alcohol – *(amount/day)* ______________

Coffee/Tea – *(cups/day)* ______________

Rec. Drugs *(List)* ______________

Patient No: __________

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INFORMED CONSENT TO
CHIROPRACTIC TREATMENT
CAROLINA CHIROPRACTIC WELLNESS GROUP INC
408 2ND Ave NE, Hickory, NC 28601- (828) 322-4787

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays, on me or the person name below for whom I am legally responsible: ___________________, by Dr. Jason M. Boehme and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by Dr. Jason M. Boehme and/or with other licensed Physicians of Chiropractic whom may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Jason M. Boehme, and /or with other office personal the nature and purpose of chiropractic adjustments and other procedures. I understand that the results are not guaranteed.

I understand and am informed that as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks. I do not expect the physician to be able to anticipate and explain all risk and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests, at the time, base upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present conditions(s) for which I seek treatment at this facility.

____
Print Patient's Name

______________________________ ______________________

Patient Signature Date

To be completed if patient is a minor or physically incapacitated:

______________________________ ______________________

Patient's Name Date

______________________________ ______________________

Patient's representative Relationship

CAROLINA CHIROPRACTIC WELLNESS GROUP, INC.
408 2ND Ave NE, Hickory, NC 28601
*Direct: (828) 322-4787 * Fax: (828) 322- 4789*

Authorizations/Assignment:

I authorized the office of Carolina Chiropractic Wellness Group, INC to release any and all information concerning my physical condition to any insurance company, adjuster, or attorney in order to process any of my claims for reimbursement of charges incurred by me as a result of professional chiropractic services rendered by Dr. Jason M. Boehme. I also authorized the release of any and all information concerning my physical condition to my employer, if and when applicable.

I authorized Dr. Boehme, and/or his office to be given Power Of Attorney to endorse/sign my name on any and all checks issued to this office toward the payment of my bill. I release Dr. Boehme and /or his office of any consequence thereof and understand that if this office should receive more than owed, I will received a refund of any credit balance due to me, the patient.

I authorized any insurance company, attorney, adjuster, or employer to make direct payment to Carolina Chiropractic Wellness Group, Inc. for any sum I should owe, now or hereafter. This authorization includes payment of any disability medical payment, no fault, or other insurance benefit on my behalf to protect the interest of Dr. Boehme.

I understand that if any insurance company, attorney, adjuster, or employer involved refuses to protect the interest of Dr. Boehme or his office, then payment is due IN FULL when services are rendered.

____
Print Patient's Name

______________________________ Patient Signature	________________________ Date

To be completed if patient is a minor or physically incapacitated:

______________________________ Patient's Name	________________________ Date
______________________________ Patient's representative	________________________ Relationship

CAROLINA CHIROPRACTIC WELLNESS GROUP, INC.
408 2ND Ave NE, Hickory, NC 28601
*Direct: (828) 322-4787 * Fax: (828) 322- 4789*

Acknowledgment of Privacy Notice & Assignment/Authorization

Purpose of Consent: By signing this form, you will consent to our use and disclosure of you protection health information to carry out treatment and payment activities.

You have the right to read and/or obtain our Notice of Privacy Practices before you sign this consent. A copy is posted at our front desk. This Notice details how your personal information will be used and disclosed in our office as permitted under federal and state law.

_______________________________ _____________
Signature Date

Additional Access to PHI

If you would like someone other than yourself to have access to your medical file ad records please list their name(s) below. **(DO NOT INCLUDE DOCTOR'S OFFICES/HOSPITALS)**

Name:

____

____

____

____

__________________________ _______________
Patient Signature Date

Carolina Chiropractic Wellness Group, INC
408 2nd Ave NE, Hickory NC 28601
(828) 322-4787- (828) 322-4789 Fax-
Email: contact@carolinachirogroup.com

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: ___________________________ **Last Name**:__________________________

DOB: _____/_____/______

Preferred method of communication for the patient reminders*(Circle One)*:
Text / Email / Phone / Mail

**WE have a Messaging system that will automatically send an appointment reminder 24 hours before your next scheduled appointment and will automatically send any office updates/schedule changes via text messaging or email. Also, posted on Social Media: Facebook for office closures.*

Specific Authorizations

- ❑ I give permission to **Carolina Chiropractic Wellness Group, INC** to use my address, phone number and clinician records to contact me with birthday cards, holiday related cards, newsletters and information about treatment alternatives or other health related information.

- ❑ I give permission to **Carolina Chiropractic Wellness Group, INC** to use my name within the office for the purpose of our referral board, patient of the month announcement, testimonials.

By Signing this form you are giving **Carolina Chiropractic Wellness Group, INC** permission to use and disclose disclose your protected health information in accordance with the directives listed above.

Patient Signature: ____ *Date:* ______________

Right to Revoke Authorization

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.
You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of ***Carolina Chiropractic Wellness, INC****. The written notice must contain the following information:*
Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request and your signature.