PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: *(First MI Last)* _____ **Preferred Name:** _____

DOB: _____ **Gender:** M / F **SSN:** _____ **Email:** _____

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

Mobile Phone: _____ **Home Phone:** _____

Job Status: Not Employed / Employed / Part-time Student / Full-time Student **Employer:** _____

Marital Status: Single / Married / Other

Who may we thank for referring you to our office? _____

Preferred Language: English / Spanish / Other: _____ **Ethnicity:** Hispanic or Latino / Not Hispanic or Latino / Decline

Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline

Smoking Status: Everyday / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Name: _____ **Primary Care Physician:** _____

Phone: _____ **Doctor's Office:** _____

Relationship: Child / Parent / Spouse / Other: _____ **May we send health updates to this physician?** Y / N

FINANCIAL INFORMATION

Is today's visit the result of an accident? No / Auto / Work / Other _____

Will we be working with Insurance? No / Yes *(Complete Details Below)*

PRIMARY INSURANCE

Insurance Carrier: _____

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

Other than Self:

Insured's Name: _____

DOB: _____ **Gender:** M / F

SECONDARY INSURANCE

Insurance Carrier: _____

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

Other than Self:

Insured's Name: _____

DOB: _____ **Gender:** M / F

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature _____ Date _____

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

AUTO ACCIDENT QUESTIONNAIRE

ACCIDENT INFORMATION *(Please use back of this page if needed.)*

Date of Accident: _____ **Approximate Time of Accident:** _____ **Number of People in Accident Vehicle** _____

Location/Street of Accident: _____

Were you the: □ Driver □ Front Passenger □ Rear Passenger – Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row

Name of Driver *(If not you)* _____ **Name of Driver of Other Vehicle** _____

Year/Make/Model of Vehicle you were in: _____

Were you wearing a seatbelt? □ Yes □ No **Is vehicle equipped with airbags?** □ Yes □ No **Did airbags inflate?** □ Yes □ No

Where was your vehicle impacted? □ Front □ Rear □ Driver side □ Passenger side

During impact, where were you facing? □ Forward □ Backward □ Left □ Right

Did any part of your body strike anything in the vehicle? □ No □ Yes *(Describe)* _____

_____

Did you lose consciousness? □ No □ Yes **For how long?** _____

Were you □ Aware □ Surprised **by the impact?**

In your own words, please describe the accident in detail: _____

_____

MEDICAL INFORMATION

Before the Accident

Have you ever had complaints in the involved area? □ No □ Yes

If yes, were they present at the time of the accident? □ No □ Yes *(Describe)* _____

Were you able to work without restrictions before the accident? □ Yes □ No

At the Time of the Accident

Did you feel pain immediately after the accident? □ Yes □ No – **When?** □ Later that Day □ Next Day □ When? _____

Did you go to a hospital or see any other doctor? □ No □ Yes – **When did you go?** □ Immediately □ Next Day □ Other

How did you get there? □ Ambulance □ Private Transportation – **Name of hospital and/or doctor:** _____

Were any x-rays taken? □ Yes □ No **Was any medication prescribed?** □ Yes □ No

Since the Accident

Are your symptoms: □ Getting Better □ Staying the Same □ Getting Worse

Have you been missed any work since this accident? □ No □ Yes *(Describe)* _____

Are your work activities restricted because of this injury? □ No □ Yes *(Describe)* _____

LEGAL INFORMATION

Did the police come to the scene of that accident? □ No □ Yes – **Was a police report files?** □ Yes □ No

Have you retained an attorney? ? □ No □ Yes – **Name** _____

Your Auto Insurance Company _____ **Policy #** _____

Other Auto Insurance Company _____ **Claim #** _____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature _____ Date _____

Print Name *(First MI Last)* _____ Account # _____

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS *(Please describe)*

Major Complaint(s): _____

Secondary Complaint(s): _____

When did this start? _____ **How did this start?** _____

_____

MAJOR COMPLAINT

Grade Intensity/Severity

- ☐ None (0/10)
- ☐ Mild (1-2/10)
- ☐ Mild-Moderate (2-4/10)
- ☐ Moderate (4-6/10)
- ☐ Moderate-Severe (6-8/10)
- ☐ Severe (8-10/10)

Frequency

- ☐ Off & On
- ☐ Constant

Quality

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy
- ☐ Dull
- ☐ Stiff & Sore
- ☐ Other: _____

Does it radiate?

- ☐ No
- ☐ Yes _____

Improves with:

- ☐ Nothing
- ☐ Ice
- ☐ Heat
- ☐ Movement
- ☐ Stretching
- ☐ OTC Medications: _____
- ☐ Other: _____

Worsens with:

- ☐ Sitting
- ☐ Standing/Walking
- ☐ Lying Down/Sleeping
- ☐ Overuse/Lifting
- ☐ Movement
- ☐ Other: _____

Previous Treatment

- ☐ None
- ☐ Chiropractor _____
- ☐ Medical Doctor _____
- ☐ Physical Therapy _____
- ☐ ER/Urgent Care _____
- ☐ Orthopedic _____
- ☐ Neurologist _____
- ☐ Other: _____

Previous Diagnostic Testing

- ☐ None
- ☐ X-rays _____
- ☐ MRI _____
- ☐ CT _____
- ☐ Other: _____

***Women:** *Are you pregnant?*

- ☐ No *Last Menstrual Period:* ___/___/___
- ☐ Yes *Due Date:* ___/___/___

Present Illness Comments:

_____

_____

Prescription Medications & Supplements: ☐ None

☐ Yes *(List – Name, dosage, frequency)*

_____

_____

_____

_____

Allergies to Medications: ☐ No known drug allergies

☐ Yes *(List - Name and reaction)*

_____

_____

_____

_____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature _____ Date _____

Print Name *(First MI Last)* _____ Account # _____

PAST, FAMILY, AND SOCIAL HISTORY

PAST MEDICAL HISTORY

Have you *ever* had any of the following? *(Please select all that apply and use comments to elaborate.)*

Illnesses:

- ☐ Asthma
- ☐ Autoimmune Disorder *(Type)* ____
- ☐ Blood Clots
- ☐ Cancer *(Type)* _____
- ☐ CVA/ TIA (Stroke)
- ☐ Diabetes
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Other: _____

Illnesses:

- ☐ Back Injury
- ☐ Broken Bones
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Falls
- ☐ Other: _____

Hospitalizations: *(Non-surgical with Date)*

_____

_____

Surgeries: *(If yes, provide type & surgery date)*

- ☐ Cancer _____
- ☐ Orthopedic
  - o Shoulder – L / R _____
  - o Elbow/Forearm – L / R ____
  - o Wrist/Hand – L / R _____
  - o Hip – L / R _____
  - o Knee – L / R _____
  - o Ankle/Foot – L / R _____
- ☐ Spinal
  - o Neck: _____
  - o Back: _____
- ☐ Other: _____

_____

Medical History Comments:

_____

FAMILY HISTORY *(Please mark **X** to all that apply and use comments to elaborate.)*

☐ Unknown ☐ Unremarkable

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death *(if deceased)*								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								

Family History Comments:

_____

SOCIAL AND OCCUPATIONAL HISTORY

Highest Level of Education:

☐ High School ☐ College ☐ Post Grad. ☐ Other

Alcohol Use:

☐ Every Day ☐ Weekly ☐ Occasionally ☐ Never

Caffeine Use:

☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Soda ☐ Never

Exercise Frequency:

☐ Daily ☐ 3-4x/wk ☐ 2-3x/wk ☐ Rarely ☐ Never

Social History Comments: _____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature_____ Date _____

Print Name *(First MI Last)*_____ Account # _____

REVIEW OF SYSTEMS

Many of the following conditions respond to chiropractic treatment.

Are you *currently* experiencing any of these symptoms? *(Please select all that apply and use comments to elaborate.)*

Constitutional: *(General)*
- ☐ Fever
- ☐ Fatigue
- ☐ Other: _____
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Joint Pain/Stiffness/Swelling
- ☐ Muscle Pain/Stiffness/Spasms
- ☐ Broken Bones_____
- ☐ Other: _____
- ☐ *None in this Category*

Neurological:
- ☐ Dizziness or Lightheaded
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Other: _____
- ☐ *None in this Category*

Psychiatric: *(Mind/Stress)*
- ☐ Nervousness/Anxiety
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____
- ☐ *None in this Category*

Genitourinary:
- ☐ Frequent or Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Painful or Irregular Periods
- ☐ Other: _____
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool or Black Stool
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains/Tightness
- ☐ Rapid or Heartbeat Changes
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Other: _____
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Other: _____
- ☐ *None in this Category*

Eyes & Vision:
- ☐ Eye Pain
- ☐ Blurred or Double Vision
- ☐ Sensitivity to Light
- ☐ Other: _____
- ☐ *None in this Category*

Head, Ears, Nose, & Mouth/Throat:
- ☐ Frequent or Recurrent Headaches
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Hearing Loss
- ☐ Sensitivity to Loud Noises
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Other: _____
- ☐ *None in this Category*

Endocrine:
- ☐ Infertility
- ☐ Recent Weight Change
- ☐ Eating Disorder
- ☐ Other: _____
- ☐ *None in this Category*

Hematologic & Lymphatic:
- ☐ Excessive Thirst or Urination
- ☐ Cold Extremities
- ☐ Swollen Glands
- ☐ Other: _____
- ☐ *None in this Category*

Integumentary: *(Skin, Nails, & Breasts)*
- ☐ Rash or Itching
- ☐ Change in Skin, Hair, or Nails
- ☐ Non-healing Sores or Lesions
- ☐ Change of Appearance of a Mole
- ☐ Breast Pain, Lump, or Discharge
- ☐ Other: _____
- ☐ *None in this Category*

Allergic/Immunologic:
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Other: _____
- ☐ *None in this Category*

Review of Systems Comments:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature_____ Date _____

Print Name *(First MI Last)*_____ Account # _____

Functional Rating Index

In order to properly assess your condition, we must understand how much your symptoms 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

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Severely Disturbed Sleep	Totally Disturbed Sleep

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

0	1	2	3	4
No Pain; No Restrictions	Mild Pain No Restrictions	Moderate Pain Need to go slowly	Moderate Pain Need assistance	Severe Pain Need 100% Assistance

4. Travel (driving, etc.)

0	1	2	3	4
No Pain on long trips	Mild pain on long trips	Moderate Pain on long trips	Moderate Pain on short trips	Severe Pain on short trips

5. Work

0	1	2	3	4
Can do usual work Plus extra work	Can do usual work No extra work	Can do 50% of Usual work	Can do 25% of Usual work	Cannot Work

6. Recreation

0	1	2	3	4
Can do All Activities	Can do Most Activities	Can do Some Activities	Can do Few Activities	Cannot do Any Activites

7. Frequency of Pain

0	1	2	3	4
No Pain	Occasional Pain 25% of day	Intermittent Pain 50% of day	Frequent Pain 75% of day	Constant Pain 100% of day

8. Lifting

0	1	2	3	4
No Pain with heavy weight	Increased Pain with heavy weight	Increased Pain with moderate weight	Increased Pain with light weight	Increased Pain with any weight

9. Walking

0	1	2	3	4
No Pain Any Distance	Increased Pain After 1 mile	Increased Pain After ½ mile	Increased Pain After ¼ mile	Increased pain With All Walking

10. Standing

0	1	2	3	4
No Pain After several hours	Increased Pain After several hours	Increased Pain After 1 hour	Increased Pain After ½ hour	Increased pain With Any Standing

Patient Signature _____ Date _____

Print Name _____ Total Score _____

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of Permenter Chiropractic, Inc. to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign Permenter Chiropractic, Inc. any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on or about _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any right I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Permenter Chiropractic, Inc., from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, worker's compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due or may become due to Permenter Chiropractic, Inc. for its services rendered.

I appoint Permenter Chiropractic, Inc. as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Permenter Chiropractic, Inc.

I authorize Permenter Chiropractic, Inc. to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Permenter Chiropractic, Inc. for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If Permenter Chiropractic, Inc. is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Permenter Chiropractic, Inc. for its costs of recovery, including reasonable attorney's fees.

I further agree this assignment of benefits (AOB) cannot be revoked and the right to receive payment cannot be transferred to any other party or re-asserted by me in any way.

_____ _____

Print Patient Name Patient Signature

_____

Date

_____

Witness

_____

Claim Number

NOTICE OF LIEN

Pursuant to N.C. § 44-49 and 44-50, Permenter Chiropractic, Inc. hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Permenter Chiropractic, Inc. hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. Permenter Chiropractic, Inc. agrees to be bound by any confidentiality agreements regarding the contents of accounting.

PERMENTER CHIROPRACTIC, INC.
TAX ID 56-2215329

Date: _____

2301 Village Lake Drive | Charlotte, NC 28212 | Phone: 704.569.3130 | Fax: 704.569.9797 | www.permenterchiropractic.com

Permenter Chiropractic

Notice of Privacy Practices

Effective January 1, 2016

Permenter Chiropractic (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is also required by law to abide by the terms of this Notice.

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 six years.

Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments (also known as spinal manipulations) and other chiropractic procedures, including various modes of physical therapeutic modalities and diagnostic X-rays on me (or on the patient named below, for whom I am legally responsible) by T. Jason Permenter, DC and/or other licensed doctors of chiropractic who now or in the future work at Permenter Chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand that the type of treatment used in this office is a low force treatment that helps reduce the possibility of the below risks but the information is provided so that I may make an informed decision.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some possible risks to treatment, including but not limited to fractures, disc injuries, VBA, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient or Guardian Signature _____ Date _____

Print Name *(First MI Last)* _____ Account # _____

DO NOT WRITE IN THIS BOX

Patient Accepted?	YES	NO	Doctor's Signature _____

2301 Village Lake Drive | Charlotte, NC 28212 | Phone: 704.569.3130 | Fax: 704.569.9797 | www.permenterchiropractic.com