Welcome to Ballantyne Advanced Chiropractic!

Last Name:___________First Name:___________MI:__Nickname:__________

Address:____

City:____________________ **State:** _____ **Zip Code:______________**

Social Security#:__________________ **Home Phone#:______________**

E-Mail:___________________________ **Cell phone#:______________**

Marital Status: S M W D DP **Sex: M F** **Birthday:**_____________ **Age** ______

Employer:____

Occupation: _____________________________ **Work Phone#:**_____________

Spouse's Name:_______________ **How did you find us:**____________________

Hobbies: ____

In case of Emergency:____________________________**Phone #:**______________

Insurance Coverage: Yes No **If yes, Name of Company:** ____________________

Name of Insured:____________________ **Insured DOB:**____________________

Insured's Place of Employment: ______________________

I, the undersigned certify that I (or my dependent) have insurance coverage with above company and assign directly to Ballantyne Advanced Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I acknowledge that I remain personally liable for the total amount due to Ballantyne Advanced Chiropractic for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____

Responsible Party Signature

HIPAA:
Protected health information (PHI) will only be released from our office with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations (TPO) and as otherwise required by law.

Patient Signature: ______________________________ **Date:** _____________

Patient Health Questionnaire

Patient Name ____
Date __________________________

1. When did your symptoms start? ________________________

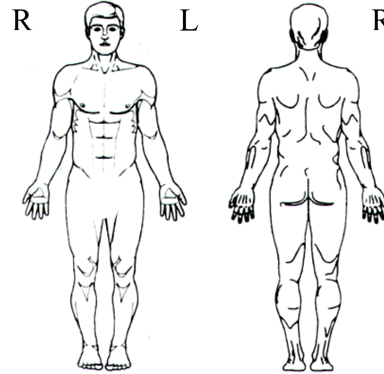
Describe your symptoms and how they began:

____

____

2. How often do you experience your symptoms? **Indicate on the body below where you have pain or other symptoms.**

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. Worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. Best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪ No complaints ① ② Mild, forgotten with activity ③ ④ Moderate, interferes with activity ⑤ ⑥ Limiting, prevents full activity ⑦ ⑧ Intense, preoccupied with seeking relief ⑨ ⑩ Severe, no activity possible

7. What activities make your symptoms worse: ____

8. What activities make your symptoms better: ____

9. Who have you seen for your symptoms?
① No One ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

a. When and what treatment? ____

b. What tests have you had for your symptoms and when were they performed?
① Xrays date: ________ ② MRI date: ________ ③ CT Scan date: ________ ④ Other date: ________

10. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?
① This Office ② Medical Doctor ③ Other ④ Other Chiropractor ⑤ Physical Therapist

11. What is your occupation? __________________________________

a. If you are not retired, a homemaker, or a student, what is your current work status?
① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other

12. **What do you hope to get from your visit/treatment** (select all that apply):

- ① Reduce Symptoms
- ② Resume/increase activity
- ③ How to prevent this from occurring again
- ④ Explanation of Condition/Treatment
- ⑤ Learn how to take care of this on my own

Patient Signature: ______________________________________ **Date:** ________________________________

Ballantyne Advanced Chiropractic ~ 704-541-7676 ~ 8634-C Camfield St., Charlotte, NC 28277

Patient Health Questionnaire – page 2

Patient Name ____ Date ___________________________

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height __________ Weight ________ lbs.
Feet Inches

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
O	O	Headaches	O	O	High Blood Pressure	O	O	Diabetes
O	O	Neck Pain	O	O	Heart Attack	O	O	Excessive Thirst
O	O	Upper Back Pain	O	O	Chest Pains	O	O	Frequent Urination
O	O	Mid Back Pain	O	O	Stroke	O	O	Smoking/Tobacco Use
O	O	Low Back Pain	O	O	Angina	O	O	Chronic Sinusitis
O	O	Shoulder Pain	O	O	Kidney Stones	O	O	Allergies
O	O	Elbow/Upper Arm Pain	O	O	Kidney Disorders	O	O	Depression
O	O	Wrist Pain	O	O	Bladder Infection	O	O	Systemic Lupus
O	O	Hand Pain	O	O	Painful Urination	O	O	Epilepsy
O	O	Hip/Upper Leg Pain	O	O	Loss of Bladder Control			
O	O	Dermatitis/Eczema/Rash						
O	O	Knee/Lower Leg Pain	O	O	Prostate Problems	O	O	HIV/AIDS
O	O	Ankle/Foot Pain	O	O	Abnormal Weight Gain/Loss			
O	O	Jaw Pain	O	O	Loss of Appetite	**Females Only**		
O	O	Joint Swelling/Stiffness	O	O	Ulcer	O	O	Birth Control Pills
O	O	Arthritis	O	O	Abdominal Pain	O	O	Hormonal Replacement
O	O	Rheumatoid Arthritis	O	O	Hepatitis	O	O	Pregnancy
O	O	Liver/Gall Bladder Disorder						
O	O	General Fatigue	O	O	Cancer	**Other Health Problems/Issues**		
O	O	Muscular Incoordination	O	O	Tumor	O	O	
O	O	Visual Disturbances	O	O	Asthma	O	O	
O	O	Dizziness	O	O	Drug/Alcohol Dependence			

Indicate if an immediate family member has had any of the following:
O Rheumatoid Arthritis O Heart Problems O Diabetes O Cancer O Lupus O _________________

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

List all the surgical procedures you have had and times you have been hospitalized:

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

Patient Signature: ____ **Date:** _____________________________

Doctor's Additional Comments

____
____
____

Doctor's Signature: ____ **Date:** ___________________________________

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic exercise, traction, or muscle/massage therapy may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following: over-the-counter analgesics; medical care (typically anti-inflammatory drugs, tranquilizers and analgesics); hospitalization in conjunction with medical care; surgery in conjunction with medical care.

Risk of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

We do not offer to diagnose or treat any disease or condition other than subluxations. However, we recognize that often people have diseases and conditions that may resolve while under chiropractic care. If during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of a health care provider who specializes in that area.

I have read the above statements and fully understand them. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing chiropractic treatment and have freely decided to do so. Therefore, I hereby give my full consent to treatment.

Unless otherwise noted below, I authorize Ballantyne Advanced Chiropractic to take any x-rays necessary during the course of my chiropractic care. I recognize that it is my responsibility to notify the doctor if there is any possibility that I am pregnant. I further recognize that at any time during the course of my care I may decline to have an x-ray examination.

_____ I am, or possibly am, pregnant and, therefore, do not authorize having x-rays taken

PATIENT PRINTED NAME **PATIENT SIGNATURE** **DATE**

The above patient is under 18 years of age and, therefore, a minor. I am the parent or guardian of the above named patient and do hereby authorize, request and direct the doctor to perform in his/her judgment any necessary examination, x-rays and chiropractic care.

PARENT/GUARDIAN PRINTED NAME **PARENT/GUARDIAN SIGNATURE** **DATE**

BALLANTYNE ADVANCED CHIROPRACTIC
8634-C Camfield Street Charlotte, NC 28277