

Mt. Olive Chiropractic Clinic

515 West Main Street

Mt. Olive, NC 28365

919-658-0003

Today's Date: ____/____/____

Name: _____ D.O.B. ____/____/____ Age: ____

 First Middle Last
Preferred Name: _____ SS# _____ Sex: Male Female

Address: _____ City: _____ State: _____ Zip: _____

Home # ____-____-____ Cell# ____-____-____ Work# ____-____-____

Married Single Other: _____ #Children? ____ Ages: _____

Email: _____ How did you hear about us: _____

Employer: _____ Occupation: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Spouse/Parent Name: _____ Phone# ____-____-____

Spouse/Parent Employer: _____ Work# ____-____-____

Emergency Contact: _____ Phone# ____-____-____

Reason For Your Visit

Pain Symptoms Wellness Visit Auto Accident Work Related Injury

Sports Injury Other Injury: _____

Date of Injury/Onset of Symptoms: _____

Primary Symptoms: (check all that apply)

<input type="checkbox"/> Headache	<input type="checkbox"/> Migraines	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Neck Stiffness	<input type="checkbox"/> Mid-Back Pain
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Arm Pain: L/R	<input type="checkbox"/> Leg Pain L/R	<input type="checkbox"/> Hip Pain: L/R	<input type="checkbox"/> Upper Back Pain
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Discomfort	<input type="checkbox"/> Weakness	<input type="checkbox"/> Tingling	<input type="checkbox"/> Soreness
<input type="checkbox"/> Shoulder Pain L/R	<input type="checkbox"/> Elbow Pain L/R	<input type="checkbox"/> Tension	<input type="checkbox"/> Head Feels Heavy	<input type="checkbox"/> Knee Pain L/R
<input type="checkbox"/> Pins/Needles in the Arms/Legs	<input type="checkbox"/> Numbness in Toes/Fingers			

Additional Symptoms: _____

Describe Your Pain & Circle on the Picture: (check all that apply)

Severity:

Mild Mild to Mod Moderate Mod to Severe Severe

Frequency:

Once Intermittent Occasional Frequent Constant

Quality:

Dull Medium Sharp Stabbing Burning

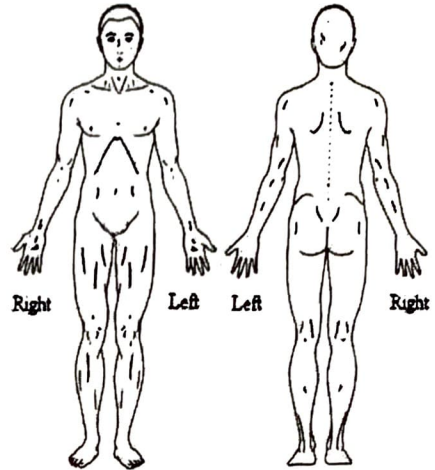
Pain is Worse:

Morning Midday After Work Evening Night

Symptoms Increase With:

Work Activity Exercise Rest Sitting Standing

Bending Walking Other



Describe on a scale of 0 (no pain) to 10 (severe pain) "How do I feel?":

Circle: 0 1 2 3 4 5 6 7 8 9 10

Overall, how do you feel? _____

Your Medical Doctor: _____ **Last Exam** _____

List Any Current Allergies _____

Current Medications You Are Taking: _____

Surgeries/Procedures: _____

Have you recently slept on: your stomach a couch a new bed the floor a recliner?

Have you recently taken a long trip? Duration of trip? _____ Mode of transportation? _____

Have you had chiropractic care before? Yes No If yes, with whom? _____

Have you seen other doctors for this condition? Yes No If yes, whom? _____

Have you ever had this problem in the past? Yes No When/How often? _____

Have you lost time from work due to your condition? Yes No Dates: _____

Do you smoke? Yes No If yes, how much? _____ # per day

Do you drink alcohol? Yes No If yes, how much? _____ # per day/week/month

Exercise? Yes No How often? _____ Type: _____

Name: _____ Date: _____

On the drawings below please indicate where you are experiencing pain by drawing in the letter abbreviation(s) on the diagrams that most accurately reflect the type of discomfort that you have been experiencing.

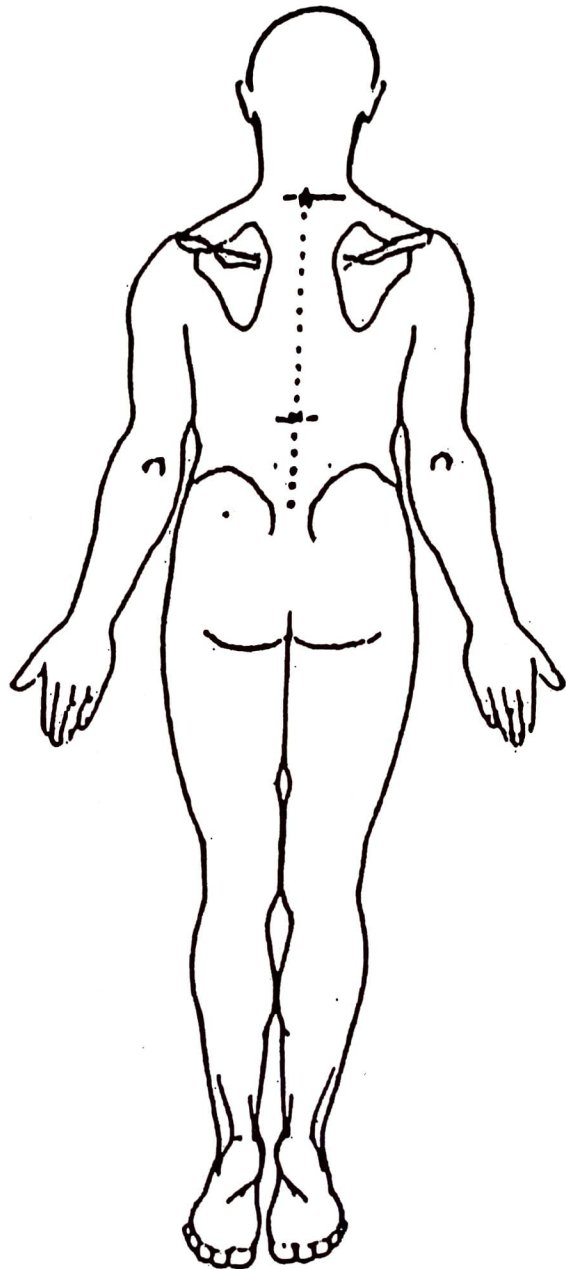
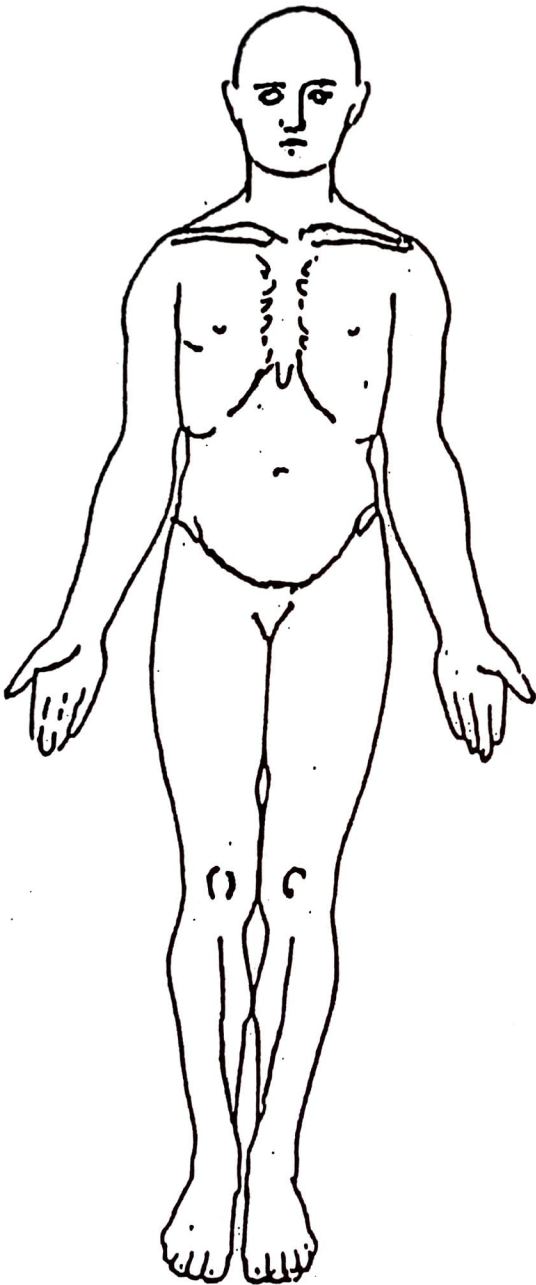
Numbness = N
Sharp Pain = P

Tingling = T
Burning = B

Dull Pain = D
Stiffness = S

Achy = A
Muscle Spasm = M

0-10



Mt. Olive Chiropractic Clinic

Patient History Form

Today's Date

Signature of Patient _____

Patient Title: (check one) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Primary Phone: _____ Work Phone: _____

Mobile Phone: _____

Home Email: _____ Work Email _____

(By providing my email address, I authorize my doctor to contact me via the email address(es) provided.)

Which email address would you like us to use to communicate with you? (check one) Home Work

Contact Method (check one)

Primary Phone Secondary Phone Mobile Phone Home Email Work Email

Date of Birth Age _____ Gender (check one) Male Female Unspecified

Marital Status (check one) Single Married Other SSN _____

Employment Status (check one)

Employed FT Student PT Student Other Retired Self Employed

Race (check one)

White Black/African American Hispanic American Indian/Alaskan Native
 Asian Asian Indian Chinese Filipino
 Japanese Korean Vietnamese Native Hawaiian or other Pacific Island
 Samoan Guamanian or Chamorro Other _____ I choose not to specify

Multi-Racial (check one) Yes No Unknown

Ethnicity (check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language (check one)

English Spanish American Sign Language Chinese French German
 Tagalog Vietnamese Italian Korean Russian Polish
 Arabic Portuguese Japanese French Creole Greek Hindi
 Persian Urdu Gujarati Armenian I choose not to specify

Continued ...

Do you currently smoke tobacco of any kind? Yes Former smoker Never been a smoker
 If yes, how often do you smoke: Current every day smoker Current sometimes smoker
 If yes, what is your level of interest in quitting smoking?
 0 1 2 3 4 5 6 7 8 9 10
 No interest Very Interested

List Current medications:
 If there are no current medications, check here:

<u>Medication:</u>	<u>Dosage:</u>	<u>Frequency:</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

List Medication Allergies:
 If no allergies are known, check here:

<u>Medication Allergy:</u>	<u>Reaction:</u>	<u>Date Began:</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Briefly list your main health problems: _____

Has any doctor diagnosed you with Hypertension presently? Yes No If yes, what : _____

Has any doctor diagnosed you with Diabetes presently? Yes No If yes, what kind? Type I Type II
 If yes to Diabetes, was your blood lab-work test for hemoglobin A1C > 9.0%? Yes No Not Sure
 May we obtain a copy of your A1C? Yes No List managing doctor: _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? Yes No

To be performed by clinic staff:
 Height: _____ inches Weight: _____ pounds BP: _____ / _____



MT. OLIVE

CHIROPRACTIC CLINIC

Dr. Massoud Motamed, D.C.
Dr. Iman Motamed, D.C.
Dr. Shanta Motamed, D.C.

515 West Main St.
Mt. Olive, NC 28365
(919) 658-0003

Disclosure & Consent Chiropractic Adjustments & Care

To the patient: You have a right as a patient to be informed about your condition, the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a back-up for the doctor of chiropractic named below.

I have had the opportunity to discuss my diagnosis, the nature and purpose of chiropractic adjustments, other procedures and alternatives with the doctor of chiropractic named below. I understand and am informed that, in the practice of chiropractic, there are some risks to the examinations and treatments including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains, increased symptoms, increased pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels right at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions, and all of my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

To be completed by the patient:

Patient's name

Signature of patient or patient's representative

Date signed

Member of doctor's staff

Date signed

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

Printed Name

Authorized Provider Representative

Signature

Date

Date

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

This notice is effective as of _____ . This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient name printed

Date

Patient Signature

Authorized Provider Representative

Personal Representative Printed

Personal Representative Signature

Description of personal representative's authority to act for the patient.