Welcome to
Mars Hill Chiropractic Center

342 Carl Eller Road Mars Hill NC 28754
Telephone # (828) 689-3777
Fax # (828) 689-5435

Today's Date: _____

Full Name: _____

Name you prefer to be called: _____

Address: _____

_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Medical Doctor: _____

Practice Name: _____
(example: Mars Hill Medical Center)

Marital Status (circle): single married divorced widowed

Birthdate: _____ **Age:** _____

Referred by: _____

Work Status: _____

Employer: _____

Occupation: _____

# of children: _____ **Age(s):** _____

Emergency Contact Person: _____

Emergency Contact #: _____

Relationship to you: _____

Is your pain or injury the result of an accident? ___ YES ___ NO

If yes, was it: ___ auto accident ___ injury ___ accident at work

Please read and initial:

___ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between doctor and patient.

___ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our business manager. If account is not paid within 90 days of date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collection of your account.

___ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status or any changes to the information I have provided on this form.

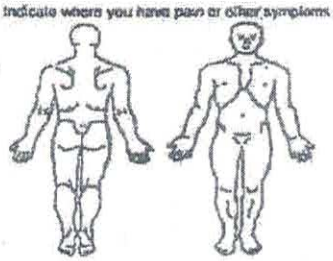
Signature: _____ Date: _____

Patient:_____ **D.O.B.**_____ **Date:**_____

1. Briefly Describe your **PRIMARY** complaint:_____

_____

Indicate where you have pain or other symptoms



2. Pain is: Sharp Dull Burning Throb Stabbing Numb Ache Other
3. When did your **symptoms** start?_____
4. How did your **symptoms** start? _____
5. Average **pain** intensity:
   In the last 24 hours: no pain **1 2 3 4 5 6 7 8 9 10** worst pain
   In the past week: no pain **1 2 3 4 5 6 7 8 9 10** worst pain
6. How often do you experience your symptoms?
   Constantly (75-100% of the time) Frequently (50-75% of the time) Occasionally (25-50% of the time) Intermittently (0-25%)
7. How are your **symptoms** changing? o Getting better o Not changing o Getting worse
8. What makes your **symptoms** better?_____
9. What makes your **symptoms** worse?_____
10. Have you had this **problem** examined by anyone else?_____
11. What have you done to treat this **problem**?_____

Additional complaints:

1._____

2._____

3._____

Current Medications, including dosage if known. If there are no current medications, check here: O

1)_____ 5)_____

2)_____ 6)_____

3)_____ 7)_____

4)_____ 8)_____

List any known allergies you have had to medications. If no allergies are known, check here: O

1)_____ 2)_____

Has your doctor diagnosed you with High Blood Pressure presently? O Yes O No If yes, describe:

_____

Has your doctor diagnosed you with Diabetes presently? O Yes O No If yes, what kind? Type 1 Type 2

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

_____

MARS HILL CHIROPRACTIC CENTER

Functional Rating Index

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	Greatly 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 some 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 unlimited 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 a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the 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 1/2 mile	Increased pain after 1/4 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 1/2 hour	Increased pain with any standing

PATIENT NAME_____ DATE_____

Patient Health Questionnaire

Patient Name _____ Date _____

What type of regular exercise do you perform? o None o Light o Moderate o Strenuous

What is your height & weight? Height ____ ft ____ in. Weight _____ lbs.

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	
O	O	Headaches
O	O	Neck Pain
O	O	Upper Back Pain
O	O	Mid Back Pain
O	O	Low Back Pain
O	O	Shoulder Pain
O	O	Elbow/Upper Arm Pain
O	O	Wrist Pain
O	O	Hand Pain
O	O	Hip/Upper Leg Pain
O	O	Knee/Lower Leg Pain
O	O	Ankle/Foot Pain
O	O	Jaw Pain
O	O	Joint Swelling/Stiffness
O	O	Arthritis
O	O	Rheumatoid Arthritis
O	O	General Fatigue
O	O	Muscular Incoordination
O	O	Visual Disturbances
O	O	Dizziness

Past	Present	
O	O	High Blood Pressure
O	O	Heart Attack
O	O	Chest Pains
O	O	Stroke
O	O	Angina
O	O	Kidney Stones
O	O	Kidney Disorders
O	O	Bladder Infection
O	O	Painful Urination
O	O	Loss of Bladder Control
O	O	Prostate Problems
O	O	Abnormal Weight Gain/Loss
O	O	Loss of Appetite
O	O	Abdominal Pain
O	O	Ulcer
O	O	Hepatitis
O	O	Liver/Gall Bladder Disorder
O	O	Cancer
O	O	Tumor
O	O	Asthma
O	O	Chronic Sinusitus

Past	Present	
O	O	Diabetes
O	O	Excessive Thirst
O	O	Frequent Urination
O	O	Smoking/Use Tobacco Products
O	O	Drug/Alcohol Dependence
O	O	Allergies
O	O	Depression
O	O	Systemic Lupus
O	O	Epilepsy
O	O	Dermatitis/Eczema, rash
O	O	HIV/AIDS

Females Only

O	O	Prescription Birth Control
O	O	Hormonal Replacement
O	O	Pregnancy

Other Health Problems/Issues

O O _____
O O _____
O O _____

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 Other: _____

_____

_____

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

_____

_____

Patient Signature: _____ Date: _____

Mars Hill Chiropractic Center

Mars Hill Chiropractic Center
Financial Agreements

The best attention can be given to you and your health concerns when we know that you expect of us, and you know what we expect of you.

Ultimately **YOU** are responsible for all charges at this office, not your insurance company. It is your responsibility to communicate with your insurance company. We will help whenever possible.

If it appears that you have insurance which will cover a portion of your charges at this office, and they deny coverage, the balance will be your responsibility.

Upon completion of treatment for a particular condition, many people continue on with preventative/maintenance chiropractic care with very satisfying results. However, since your insurance company will not cover maintenance services, we will offer you a cash discount, if paid at time of services. We do not file maintenance visits with your insurance company.

Below is a fee schedule that lists many of the common services at this office.

Initial exam	$98.00	X-rays per region	$50.00
Reexam	$50.00	Manual therapy (muscle treatment)	$14.00
Adjustment of 1-2 regions	$38.00	Kinesiology testing	$14.00
Adjustment 3-4 regions	$49.00	Intersegmental traction	$14.00
Urinalysis	$10.00	Wellness adjustment	$38.00
Interferential current	$14.00	(paid at time of service)	

There will be a $25.00 fee for any returned checks.

Past due accounts are subject to a 10% per month billing charge.

I have read and accept the above financial agreements.

Signature of Patient: _____ Date: _____

Or signature of Parent or Guardian: _____ Date: _____

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 Mars Hill Chiropractic Center may have to use or disclose your health care information. We may have to disclose your health information

- to another health care provider for referral to them for treatment or diagnosis
- to an insurance company or another party if they are responsible for payment of your services for treatment
- amongst the staff within our practice for quality control or administrative purposes.

Your right to limit uses or disclosures

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Mars Hill Chiropractic Center will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Mars Hill Chiropractic Center's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice at any time.

Signature:_____ Date:_____

Printed Name:_____

INFORMED CONSENT TO CHIROPRACTIC CARE

We provide adjustments or manual manipulations through the gentle application of a targeted movement where and when indicated by a licensed Doctor of Chiropractic to improve motion of the body's spinal column and extremities.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches, and other similar symptoms. Routine chiropractic treatment can result in better function, improved joint motion, and a healthier, more active lifestyle.

However, there are some risks associated with the chiropractic adjustments, including, but not limited to the possibility of sprains, dislocations, and fractures. In addition:

1. While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques.
2. There are reported cases of stroke associated with neck movements including adjustments of the upper cervical spine. Current medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because a stroke may cause serious neurological impairment and result in injuries including paralysis.
3. There are reported cases of disc injuries following a cervical and lumbar spinal adjustments or chiropractic treatment.

The risk of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and surgical procedures given for the same treatments.

Common alternatives to adjustments and manipulations include medications, physical therapy, or medical treatments and surgery provided by physicians and surgeons.

By signing this informed consent, I acknowledge that I have discussed, or have had the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments), the benefits, risks and alternatives to chiropractic treatment.

I consent to the chiropractic treatments offered or recommended to me by my Doctor of Chiropractic, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care received from Mars Hill Chiropractic Center.

Patient Printed Name_____

Patient Signature_____

Legal Guardian Signature_____

Date_____ Witness Signature_____