Satterwhite Chiropractic of Oxford

Patient Data **Date** ____

Title: (Check one) □ Mr. □ Mrs. □Ms. □ Miss □ Dr. □ Other _____

First Name _____ Middle Initial ____ Last Name _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Cell Phone (_____) _____-_____ Email _____

Date of Birth _____/_____/_____ Age: _____ **Sex:** □ Male □ Female

Social Security Number: _____-_____-_____ Marital Status: □ Single □ Married □ Other

Employment Status: □ Employed □ Unemployed □ FT Student □ PT Student □ Other_____

Spouse Data ____

First Name _____ Middle Initial _____ Last Name _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Employer Data ____

Name _____

Your Occupation _____ Your Job Description _____

Address _____

City _____ State _____ Zip Code _____

Emergency Contact ____

Contact Name _____ Relationship to Patient _____

Contact Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Doctor's Signature _____

Patient Name_____ **Date**_____

Medical Conditions: (Check all that apply to you)

□ Arthritis □ Cancer □ Diabetes □ Heart Disease
□ Hypertension □ Psychiatric Illness □ Skin Disorder □ Stroke
□ Other _____ ☐ Have you ever had any serious falls, accidents, strains, hospitalizations, surgeries, length illnesses? ☐ **YES** ☐ **NO** If so please describe: _____
_____

Surgeries: (Check all that apply to you)

□ Appendectomy □ Cardiovascular procedure □Cervical spine □ Hysterectomy
□ Joint Replacement □ Prostate □ Lumbar spine □ Gall Bladder
□ Brain □ Shoulder □ Thoracic spine □ Knee
□ Carpal Tunnel □ Gastro-intestinal □ Uro-genital □ Hernia
□ Other _____

Allergies: (Check all that apply to you)

□ Eggs □ Fish and Shellfish □ Milk or Lactose □ Peanuts
□ Soy □ Sulfites □ Wheat/Glutens □ Other _____

Social History: (Check all that apply to you)

Caffeine use:	□ occasional	□ often	□ never
Drink Alcohol:	□ occasional	□ often	□ never
Exercise:	□ occasional	□ often	□ never
Chew Tobacco:	□ occasional	□ often	□ never
Cigarettes:	□<1 pack/day	□ >1 pack/day	□ never
Wear Seat Belts:	□ occasional	□ always	□ never

Other _____

Family History: (Check all that apply)

Arthritis:	□ Parent	□ Sibling	Mother: Alive Deceased Age: _____
Cancer:	□ Parent	□ Sibling	Cause of Death: _____
Diabetes:	□ Parent	□ Sibling	Health Problems: _____
Heart Disease	□ Parent	□ Sibling	
Hypertension	□ Parent	□ Sibling	Father:: Alive Deceased Age: _____
Stroke	□ Parent	□ Sibling	Cause of Death: _____
Thyroid	□ Parent	□ Sibling	Health Problems: _____

Other _____

Occupational Activities: (Check one that best describes your job description)

□ Administration □ Business Owner □ Clerical/Secretary □ Computer User
□ Heavy Equipment operator □ Daycare/Childcare □ Construction □ Health Care
□ Food Service Industry □ Medium Manual Labor □ Manufacturing □ Home Services
□ Heavy Manual Labor □ Light Manual Labor □ Executive/Legal □ Housekeeper
□ Other _____

Doctor's Signature _____

Patient Name **Date**

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Please list all current medications being taken _____

_____

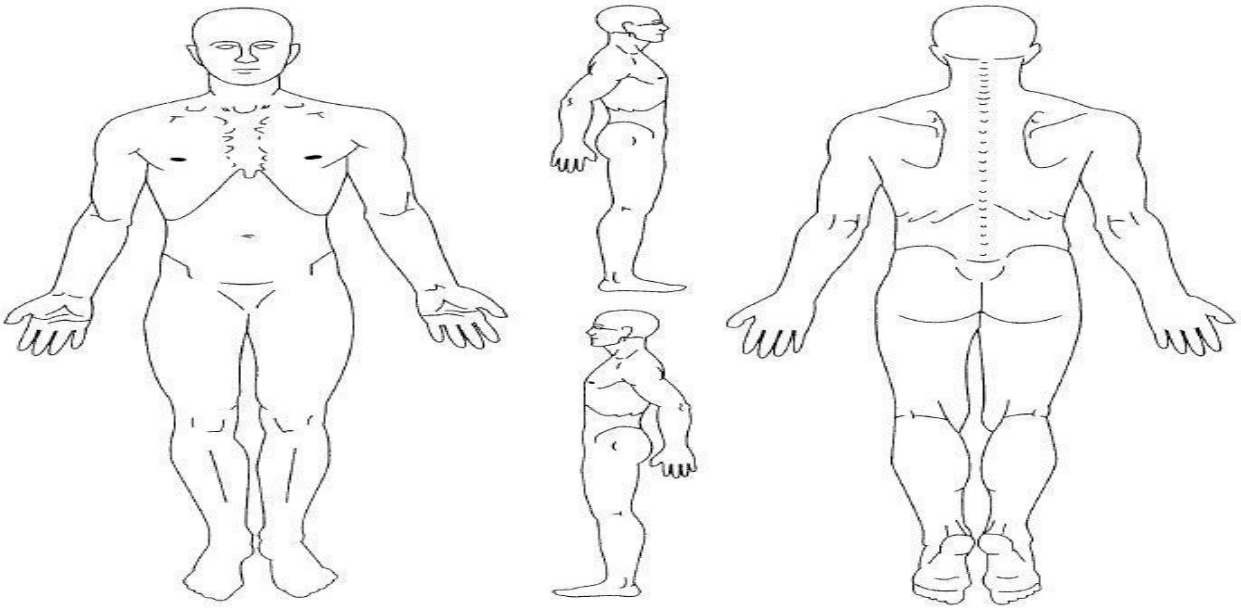
_____

Doctor's Signature _____

Patient Name_____ Date_____

Are you pregnant? Yes_____ No _____N/A_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms: N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache
Pain Level: 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)



Describe your (complaints) symptoms in order of severity, with worse (complaints) symptom being #1: _____
_____

When did your symptoms begin? Month_____ Day_____Year _____

Are your symptoms a result of: □ Motor Vehicle Accident □Work related Accident □ Other_____

Please describe what makes your symptoms worse: _____

Please describe what makes your symptoms better: _____

What doctors have you seen for this condition(s): _____

What medications are you taking for this condition: _____

How often do you experience your symptoms?

□ Constantly (76-100% of the day)	□ Frequently (51-75% of the day)	□ Intermittently (26-50% of the day)	□ Occasionally (0-25% of the day)

What describes the nature of your symptoms?

□ Sharp	□ Dull ache	□ Numb	□ Shooting
□ Burning	□ Tingling	□ Stabbing	□ Other _____

Doctor's Signature _____

Patient Name **Date**

How are your symptoms changing?

□ Getting better □ Not changing □ Getting worse

Employment, ADL, and Recreation Information

Outcomes Assessment Tool Used _____ Score _____

Description of Work: _____

Condition's Effect On Job Performance: □ **No Effect** □ **Mild** (painful can do) □ **Mod** (painful limited ability) □ **Mod/Sev (**limited duty) □ **Sev (**no limited duty) □ **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Care –Infirm Family:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Carrying Groceries:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Change Posn–Sit-Stand:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Climb Stairs:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Driving:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Extended Computer Use:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Feeding:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Household Chores:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Kneeling:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Lift Children:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Lifting:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Pet Care:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Reading (Concentration):	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Self Care–Bathing:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Self Care–Dressing:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Self Care–Shaving:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Sexual Activities:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Sleep:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Static Sitting:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Static Standing:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Walking:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Yard Work:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (limited)	□ **Sev** Unable to Perform
_____	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (limited)	□ **Sev** Unable to Perform
_____	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (limited)	□ **Sev** Unable to Perform

Doctor's Signature _____

Patient Name_____Date_____

Payment/Insurance Information:

Who is responsible for your bill? □ Self □ Health Insurance □ Spouse □ Worker's Comp
□ Auto Insur. □ Medicare □ Medicaid □ Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Primary Care Physician _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? □Yes □No Date: ____/____/____ Time: _____am / pm

Have you reported the auto accident with your car insurance?: □Yes □No

Name of Carrier: _____

Do you have a claim number: □Yes □No Claim Number: _____

Do you have an attorney: YES NO If yes, Attorney's Name: _____

Phone Number: _____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____
Date_____

SIGNATURE OF PHYSICIAN: _____Date: _____

Satterwhite Chiropractic of Oxford
104 Delacroix Street
Oxford NC 27565
Phone: 919-690-8858 Fax: 919-690-8091

Satterwhite Chiropractic is required by law and in compliance with HIPAA to maintain the confidentiality of your protected health information and to provide patients with notice of privacy practices with respect to health records.

We may disclose health care information to other healthcare professionals within our practice for the purpose of treatment and healthcare. It is our policy to provide another healthcare provider for your treatment during our absence.

We may disclose your health information to your insurance company for the purpose of payment. As a courtesy, we will submit an itemized statement to your insurance company for the purpose of payment for services rendered. These itemized statements include diagnosis, date of injury or condition, codes describing services rendered and charges.

Health information for patients treated under Worker's Compensation may be disclosed as necessary to comply with State Worker's Compensation Laws.

We may disclose health information to another healthcare provider in response to your referral to or from our office.

We may contact you by mail to provide appointment reminders or information about treatment, alternate treatment or other health benefits, birthday cards, holiday cards, periodic announcements and services that may be of interest to you. We **WILL NOT** ever share sell or spam your personal contact information.

In emergencies, we may disclose your health information to notify or assist in notifying a family member or other individual responsible for your care.

As required by law, we may release health information to public health authorities for purposes of preventing or controlling disease, injury or disability, reporting child abuse or neglect, domestic violence and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding, law enforcement official, complying with a court order or subpoena or other law enforcement purposes.

As a courtesy, we may call your home or leave a message, stating your next appointment date and time or missed appointments. No personal health information will be disclosed.

You have the right to request restrictions on certain uses and disclosures of your health information. If you have such a request, please notify Satterwhite Chiropractic immediately with the restrictions.

You have the right to inspect and receive a copy of your health information. Further, you have a right to request that Satterwhite Chiropractic amend your health information but they are not required to agree to amend it. If your request is denied, you will be given an explanation of denial reasons and how you can disagree with the denial.

You have a right to receive an accounting of disclosures of you health information made by Satterwhite Chiropractic.

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Satterwhite Chiropractic is required by law to maintain the privacy of your health information. If you have any questions regarding this notice, you may contact the Privacy Officer by 704-782-0111. If you need to make an appointment with the Privacy Officer you may do so by telephone or in person. If you are not satisfied with the way your complaint is handled, you may request the address to file a formal compliant.

We must disclose your health information to DHHS as necessary for them to determine our compliance with HIPAA standards.

Satterwhite Chiropractic retains the rights to add, remove or alter this agreement as deemed necessary. Any such changes will be posted in the physical premises of Satterwhite Chiropractic and shall be retroactively effective to the date of original signature.

If you have any questions about his notice please contact the following person:

Effective Date of this Notice: _____

Contact Person: Shannon L Satterwhite/Office Manager

Phone Number: 919-690-8858

Patient Acknowledgement

I have read the Privacy Notice and understand my rights contained in the notice.

I provided Satterwhite Chiropractic with my authorization and consent to use my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (printed)

_____ _____
Patients' Signature Date

_____ _____
Authorized Office Signature Date