# 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:**________________

**Birthdate:**____________________**Age:**________

**Address:**________________________________

____________________________________________

**Cell Phone:**________________________________

**Home Phone:**________________________________

**Work Phone:**________________________________

**Email:**________________________________

**Employer:**________________________________

**Occupation:**________________________________

**Marital Status**(circle): **single married divorced widowed**

**# of children:**____________**Ages:**____________

**Referred by:**________________________________

**Medical Doctor:**________________________________

**Practice Name:**________________________________

(example: Mars Hill Medical Center)

**Emergency Contact Peron:**____________________

**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:

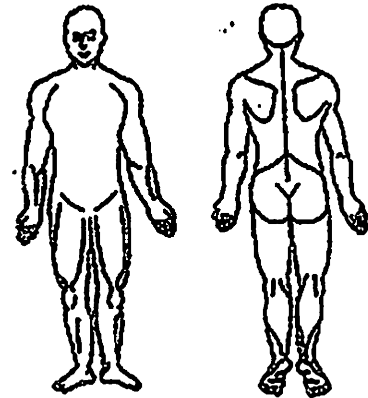
______We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between doctor and patient.

______ 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 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. Name your **PRIMARY** complaint and **indicate on diagram** where your pain is:______________________________
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? (circle below)
   **Constantly (75-100% of the time)** **Frequently (50-75% of the time)**
   **Occasionally (25-50% of the time)** **Intermittently (0-25% of the time)**
7. How are your symptoms changing? (circle below)
   **Getting better** **Not changing** **Getting worse**
8. What make your symptoms worse?________________________
9. What made your symptoms better?________________________
10. Have you had this problem examined by anyone else?________________________
11. What have you done to treat this problem?________________________

**Additional Complaints:**________________________________________

____________________________________________________________

List current medications, including dosage: If there are no current medications, check here: **O**

**1.** ____________________ **7.**____________________
**2.** ____________________ **8.** ____________________
**3.** ____________________ **9.** ____________________
**4.** ____________________ **10.**____________________
**5.** ____________________ **11.** ____________________
**6.** ____________________ **12.** ____________________

List any known allergies you have had to medications, if applicable:____________________

____________________________________________________________

Has your doctor diagnosed you with high blood pressure presently? **O Yes** **O No**

Has your doctor diagnosed you with diabetes presently? **O Yes** **O No** if yes, what kind? **Type 1** **Type 2**

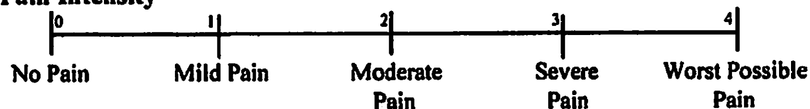
Have you had an x-ray, CT scan or MRI of your spine in the past 28 days? **O Yes** **O No**

# Mars Hill Chiropractic Center

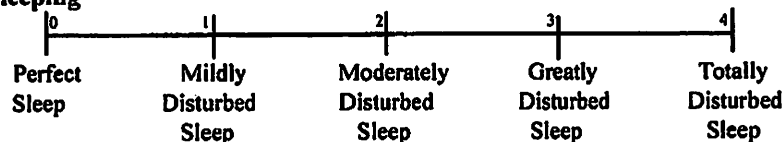
## Functional Rating Index

**For each item below, please circle the number which most closely describes your condition right now.**

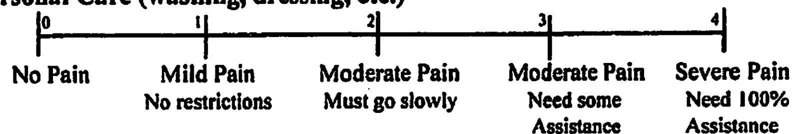
**1. Pain Intensity**




**2. Sleeping**

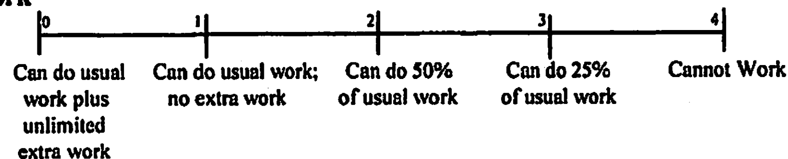



**3. Personal Care (washing, dressing, etc.)**

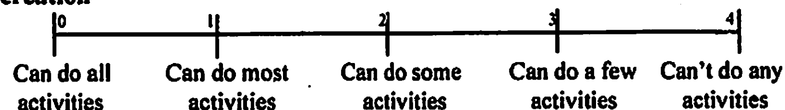



**4. Travel**

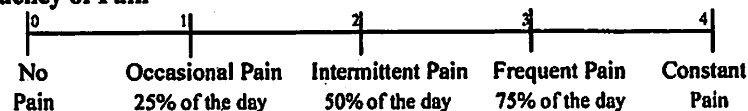
**5.Work**



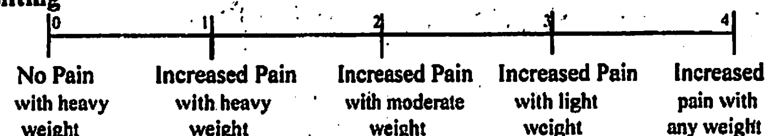

**6. Recreation**



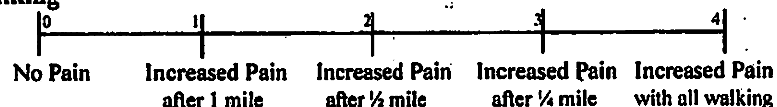

**7. Frequency of Pain**



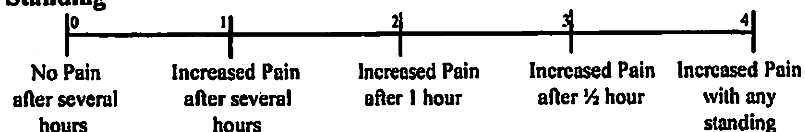

**8. Lifting**




**9. Walking**




**10. Standing**




**Patient Name:** ______________________________

**Signature:** ______________________________ **Date:** ____________________

## Patient Health Questionnaire

**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 [ ] [ ] [ ] (Feet, Inches) 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 | Condition |
|---|---|---|
| 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 | Condition |
|---|---|---|
| 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 Sinusitis |

| Past | Present | Condition |
|---|---|---|
| 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 | Birth Control Pills |
| O | O | Hormonal Replacement |
| O | O | Pregnancy |
| O | O | |
| ***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____________

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

______________________________________________________________

______________________________________________________________

**Any other health concerns the doctor should know:**

______________________________________________________________

______________________________________________________________

**Patient Signature:** ______________________________ **Date:** ____________

# CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

***Our Privacy Policy***

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 see or use 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 the 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 restriction.

***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.***

Patient Name: ______________________________

Signature: ________________________________ Date: _______________

# 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 spasms, 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 chiropractic adjustments, including, but not limited to the possibility of sprains, dislocations, and fractures. In addition:

- While rare, some patients may experience short term aggravation of symptoms, rib fractures, or muscle and ligament strains or sprains as a results of manual therapy techniques.
- 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 adjustments and the occurrence of stroke.
  - The apparent associated 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.
- There are reported cases of disc injury 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.

Dry needling is a technique that utilizes thin, solid filament needles. This needling technique is used specially to treat myofascial trigger points, muscle spasms, or dysfunctional tissue. Like any medical procedure, there are possible complications. While these complications are uncommon, they do sometimes occur. They include pain, infection, bruising or bleeding, drowsiness, fatigue and autonomic responses, and pneumothorax.

***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: ______________________________

Witness Signature: ______________________________ Date: ______________

**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.

A re-exam is **required** if you have not been treated at our office for 3 months or more. This may include an exam fee depending on your insurance coverage. (see below)

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

| | | | |
|---|---|---|---|
| Initial exam | $85.00 | Dry Needling | $15.00 |
| Reexam | $50.00 | Manual therapy (muscle treatment) | $15.00 |
| Adjustment of 1-2 regions | $43.00 | Intersegmental traction | $15.00 |
| Adjustment 3-4 regions | $50.00 | Wellness adjustment | $40.00 |
| Interferential current | $15.00 | (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: __________