Carraway Chiropractic & Laser Center
Christopher A. Carraway, DC, DIBCN
2507 Neuse Blvd., New Bern, NC 28562
(252) 636-2900

Patient Intake Form

Personal Information

Today's Date: _____

First Name: _____Middle: _____Last: _____

Date of Birth: _____ Social Security# _____

❒Female ❒Male Marital Status: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Separated

Spouse's Name:_____ Number of children: _____

Emergency Contact : _____ Relationship: _____Phone: _____

How did you choose our office? ❒ Friend/Family_____ ❒ Physician_____
❒ Internet ❒ Phone Book ❒ Newspaper Other:_____

Contact Information (Please check your preferred method of contact)

Phone # ❒ Home: _____❒ Cell: _____❒ Work: _____
❒ *I would like to receive appointment reminders and other messages via text messaging. I understand that provider data fees and/or normal text messaging rates may apply.* ***I understand that I may opt out at any time by notification in writing or by calling (252) 636-2900.*** *For help or additional information, call (252) 636-2900.*

Your Address: Street _____

City: _____State: _____ Zip: _____

Email Address: _____
(We will NOT share your email with any third party. We will only use your email in relation to your care in our office.)

Employment Information

Work Status: ❒Full time ❒Part Time ❒Unemployed ❒Retired ❒Student (full time) ❒Student (part time)

Occupation: _____

Employer: _____ City: _____ State: _____

Personal Health History

Current Conditions: Please list any health conditions that you have been treated for in the last year: _____

_____

_____

Patient Name_____**Date**_____

Past Illnesses: Have you ever had any of these conditions in the past?:

Musculoskeletal
- ❒ Arthritis (type:_____)
- ❒ Back pain
- ❒ Fractures
- ❒ Herniated disc
- ❒ Migraines
- ❒ Muscle weakness
- ❒ Neck pain
- ❒ Osteoporosis
- ❒ Polio
- ❒ Sciatica
- ❒ Spinal curvatures
- ❒ Swollen joints

Neurological
- ❒ CVA (stroke/TIA)
- ❒ Dementia/Alzheimer's
- ❒ Epilepsy
- ❒ Headache
- ❒ Loss of memory
- ❒ Dizziness/loss of balance
- ❒ Loss of smell or taste
- ❒ Multiple sclerosis
- ❒ Neuromuscular disorders
- ❒ Parkinson's
- ❒ Pinched nerve
- ❒ Seizures

Head/ENT
- ❒ Cataracts
- ❒ Glaucoma
- ❒ Macular degeneration
- ❒ Retinal disease

Cardiology
- ❒ Arteriosclerosis
- ❒ Chest pain
- ❒ Heart disease
- ❒ High blood pressure
- ❒ High cholesterol
- ❒ Pacemaker
- ❒ Swelling of ankles

Respiratory
- ❒ Asthma
- ❒ COPD/emphysema
- ❒ Pneumonia
- ❒ Shortness of breath

Gastro/Intestinal
- ❒ Digestion Problems
- ❒ Gallbladder disease
- ❒ Hernia
- ❒ Ulcers

Genitourinary
- ❒ Breast lump
- ❒ Kidney disease
- ❒ Kidney stones
- ❒ Prostate problems

Endocrine/Hemotological
- ❒ Diabetes (Type: ❒ 1 or ❒ 2)
- ❒ Bleeding disorder
- ❒ Cancer
- ❒ Hepatitis
- ❒ Liver disease/cirrhosis
- ❒ Thyroid condition

Dermatologic
- ❒ Psoriasis
- ❒ Skin cancer
- ❒ Skin disease:_____
- ❒ Shingles

Emotional/Constitutional
- ❒ Depression/Anxiety
- ❒ Fatigue
- ❒ Sleep problems/insomnia
- ❒ Unexpl. weight gain or loss

Do you have any medication, food or environmental allergies? ❒No ❒ Yes Please list: _____

_____

Please list your surgery(s): _____

_____

Please list your current medications *(including vitamins, supplements and over-the-counter) or give a copy to the receptionist:* _____

_____

Accidents/Injuries: Have you ever been in an auto or other traumatic accident? ❒No ❒ Yes Briefly explain: _____

_____

Have you ever been struck unconscious? ❒No ❒ Yes Briefly explain: _____

Family Health History

In your immediate family *(father, mother, siblings, or child),* is there a history of

❒ Stroke ❒ Diabetes ❒ Heart Disease ❒ Progressive neurological disorders

❒ Cancer ❒ High blood pressure ❒ Migraine headaches Other: _____

Patient Name_____**Date**_____

Work Habits *(if employed)*

Hours worked per week: _____ Type of work: ❒ light labor ❒ moderate labor ❒ heavy labor ❒ sedentary

Check all that apply to your work: ❒ mostly sitting ❒ mostly standing ❒ mostly walking

❒ repetitive motions ❒ computer use ❒ telephone use ❒ stressful ❒ enjoyable ❒ relaxed ❒ difficult

Social History

Do you use:

Alcohol: ❒ Never ❒ Social ❒ Light ❒ Moderate ❒ Heavy

Tobacco Use: ❒ Never smoked ❒ Former smoker ❒ Current smoker: ____ packs/day Do you chew? ❒Yes ❒No

Caffeine drinks and products: ❒ None ❒ 1 cup per day ❒ 2-4 cups per day ❒ 5 or more cups per day

Recreational drugs: ❒ Never ❒ Rarely ❒ Occasionally ❒ Frequently

Do you exercise? ❒ Never ❒ Rarely ❒ Occasionally ❒ Regularly *Type of exercise:* _____

What is your "healthy eating" level? ❒ Very healthy ❒ Somewhat healthy ❒ Not very healthy ❒ Unhealthy

Female Patients: Are you pregnant, or think you may be? ❒No ❒ Yes Due date: _____

Primary Physician: _____ Date of Last Visit: _____

Your height: _____ft. _____in. **Your weight:** _____ Are you: ❒ right handed ❒ left handed

Current Symptoms

Date of injury or onset:_____ **It occurred at:** ❒Home ❒Work ❒Auto ❒Sports ❒Other: _____

How the injury, pain or discomfort begin?: _____

_____

Please describe your discomfort: _____

Is it? ❒ Sharp ❒ Dull Ache ❒ Numb ❒ Shooting ❒ Throbbing
❒ Burning ❒ Tingling ❒ Stabbing ❒ Radiating ❒ Cramping

Please mark your pain areas on the diagram:

Please circle your current pain level on a scale of 1 to 10
(Where "0" is NO pain and "10" is unbearable pain)

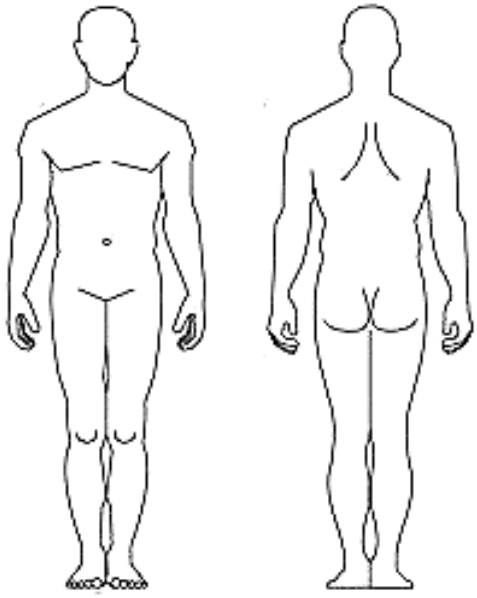
No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

What level is your pain at its best? #_____ At its worst? #_____

What percentage of the day do you experience symptoms?
10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Over time, this condition: ❒ has gotten worse ❒ has stayed constant
❒ comes and goes ❒ has improved

Are your symptoms worse:
❒ in the morning ❒ by midday ❒ throughout the day
❒ at the end of the day ❒ during the night



Patient Name_____**Date**_____

List anything that aggravates your condition: _____

List anything that improves your condition: _____

Have you had same or similar symptoms in the past? ❒No ❒ Yes When? _____

What type of treatment did you receive? _____

Have you received professional treatment for your <u>current</u> condition? ❒No ❒ Yes If yes, please explain:_____

Have you had x-rays taken for your <u>current</u> condition? ❒No ❒ Yes When/where?: _____

Does this condition interfere with any of your daily activities or routines? ❒No ❒ Yes If yes, please explain:

_____

Has this condition affected your quality of sleep or ability to sleep? ❒No ❒ Yes

Have you missed any work due to this condition? ❒No ❒ Yes Last day worked: _____

Insurance and Payment for Care

How do you plan to pay for care?

❒ Personal Health Insurance ❒ Auto/Liability Insurance ❒ No Insurance/Self Pay (cash, credit card, or check)

PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST SO WE MAY COPY THEM FOR YOUR RECORDS.

Insured's name if other than yourself: _____

Insured's date of birth: _____Relationship: _____

Insured's Employer: _____

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information by this office, and I authorize this office and its staff to examine and treat my condition as the doctor sees fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I hereby authorize my insurance benefits be paid directly to Dr. Christopher Carraway, realizing I am responsible to pay for any co-insurance, co-payments, deductibles and non-covered services. I understand that FDA cleared low level laser therapy performed in this office is considered an experimental treatment and will not be submitted to any insurance company under any circumstances for reimbursement. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient's Signature _____ Date_____

Parent or Guardian's Signature Authorizing Care for Minor

_____ Date_____

Patient Name_____**Date**_____

Please CIRCLE the number which most closely describes your ability to manage your everyday activities.

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)**

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, riding in car)**

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 unlimited work	Can do usual work, but 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	Intermittant 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 walking any distance	Increased pain after one mile	Increased pain after ½ mile	Increased pain after ¼ 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 one hour	Increased pain after ½ hour	Increased pain with any standing