CARRAWAY CHIROPRACTIC & Laser Center

Carraway Chiropractic Center, PLLC
790 Cardinal Road, Suite 3, New Bern, NC 28562

Please take a moment to fill out our intake form before your visit. All information is kept completely confidential.

First Name _____ Middle Initial ____ Last Name _____

Preferred Name (if different) _____

Home phone _____ Mobile Phone _____
(A mobile phone is required if you would like to receive SMS appointment reminders)

Street Address _____

City _____ State _____ Zipcode_____

Date of Birth _____ ❒ Female ❒ Male

Occupation _____ Employer _____

Guardian, if under 18 _____Phone_____

Emergency Contact _____Phone _____

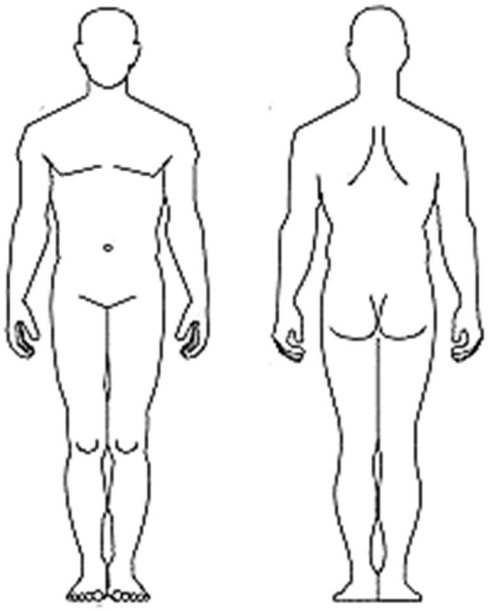
Family Doctor _____ Phone, if known_____

Referred by: ❒ Medical professional ❒ Friend ❒ Online Search ❒ Other _____

Where are you having pain or discomfort? (Please describe and mark on the figure)

_____

_____



Is your pain or discomfort:

❒ Aching
❒ Burning
❒ Dull
❒ Sharp
❒ Stabbing
❒ Throbbing
❒ Weakness
❒ Numbness/Tingling
❒ Tension
❒ Stiffness
❒ Radiating Pain

Patient Name _____ Date _____

Please circle your current pain or discomfort 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

Secondary or other areas of complaint (please provide a brief description)

_____

Were you injured in a work or car accident? ❒ Yes ❒ No If yes, describe: _____

_____

How long have you had your primary complaint? _____

What caused this problem? _____

Was the onset: ❒ Sudden or ❒ Gradual

How has your primary complaint been progressing? ❒ Getting better ❒ Staying the same ❒ Worsening

What aggravates your primary complaint? Check all that apply:

❒ Nothing ❒ Running ❒ Computer work ❒ Stress
❒ Sitting ❒ Exercise ❒ Driving ❒ Other (please describe): _____
❒ Standing ❒ Lying down ❒ Sleep _____
❒ Walking ❒ Bending ❒ Above shoulder activity

What relieves your complaint? Check all that apply

❒ Nothing ❒ Stretching ❒ Medication
❒ Heat ❒ Walking ❒ Prior chiropractic treatment
❒ Ice ❒ Rest ❒ Other (please describe): _____

Please list any treatments you have received for this issue and the results achieved: _____

_____

Health History Questionnaire (please check all that apply)

General Symptoms

❒ Loss of consciousness ❒ Night Sweats ❒ Loss of Sleep
❒ History of headaches ❒ Night Pain ❒ Allergies
❒ History of migraines ❒ Generalized Pain ❒ Loss of Bowel or Bladder Control
❒ Fever ❒ Nervousness
❒ Excess Sweating ❒ Convulsions

Neurological Symptoms

❒ Dizziness ❒ Fainting ❒ Problem Speaking ❒ Blurred Vision ❒ Nausea
❒ Numbness or tingling ❒ Radiating pain

Patient Name _____ Date _____

Eyes / Ears / Nose / Throat Symptoms

❒ Failing vision ❒ Vision problems ❒ Eye pain ❒ Ringing / Buzzing in ears
❒ Hearing loss ❒ Other hearing problems not otherwise listed _____

Respiratory Symptoms

❒ Asthma ❒ Chronic cough ❒ Difficulty breathing ❒ Shortness of breath
❒ Bronchitis ❒ Emphysema ❒ COPD

Cardiovascular Symptoms

❒ Bleeding disorder ❒ Hardening of arteries ❒ Previous heart attack(s)
❒ High blood pressure ❒ Swelling of ankles ❒ Phlebitis / varicose veins
❒ Low blood pressure ❒ Poor circulation ❒ Pacemaker or similar device
❒ Previous stroke ❒ Angina ❒ Other heart / blood disease _____
❒ Cerebral Vascular Aneurysm ❒ Chronic congestive heart failure _____

Gastrointestinal Symptoms

❒ Jaundice ❒ Irregular or absent bowel movement ❒ Ulcer
❒ Diabetes ❒ Indigestion

Genitourinary Symptoms

❒ Trouble Urinating ❒ Kidney infection ❒ Prostate trouble

Female patients:

❒ Hot flashes ❒ Irregular / absent cycle ❒ Cramping / backache

Are you currently pregnant? ❒ Yes ❒ No What is your estimated due date? _____
Number of pregnancies: _____ Number of children: _____

All Patients: Have you ever had surgery? ❒ Yes ❒ No If yes, please provide details: _____

_____

_____

Have you ever had any broken bones? ❒ Yes ❒ No If yes, please provide details: _____

_____

Have you had any x-rays, CT scans, ultrasounds or MRI's in the past 5 years? ❒ Yes ❒ No

If so, please list the clinic or hospital and the area(s) examined: _____

_____

Patient Name _____ Date _____

Have you ever been diagnosed with cancer? ❒ Yes ❒ No If yes, please provide details: _____

_____

_____

Please list your current medications and supplements: _____

_____

_____

How would you describe your overall activity level? ❒ Very active ❒ Somewhat active ❒ Not very active

How would you describe your stress level? ❒ High ❒ Moderate ❒ Low

How would you describe your eating habits? ❒ Very Healthy ❒ Somewhat healthy ❒ Not Healthy

Family Medical History (Please check if any immediate family members have suffered from the following)

❒ Headaches or Migraines	❒ Cancer	❒ Osteoarthritis
❒ High or low blood pressure	❒ Neurological disorders	❒ Osteoporosis
❒ Diabetes	❒ Kidney disease	❒ Rheumatoid arthritis
❒ Heart disease	❒ Inflammatory bowel disease	❒ Epilepsy
❒ Fainting or dizziness	❒ Asthma	❒ Multiple sclerosis
❒ Stroke	❒ Respiratory disorders	❒ Circulatory problems

Please list any additional information that you feel is pertinent: _____

_____

_____

_____

Accuracy of Information

❒ I certify that the above medical information is correct to my knowledge.

Privacy and Sharing of Information

I authorize Carraway Chiropractic Center PLLC and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and /or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

_____ _____

Signature of Patient or Legally Authorized Person Date

Patient Name _____ Date _____

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including low level laser therapy, various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by Dr. Christopher A. Carraway and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by Dr. Christopher A. Carraway and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Christopher A. Carraway and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure(s) which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

_____ _____

Signature of Patient or Legally Authorized Person Date

Patient Name _____ Date _____

CONSENT TO USE PROTECTED HEALTH INFORMATION (PHI)

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Carraway Chiropractic Center, PLLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy.

_____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____

Signature of Patient or Legally Authorized Person Date

Patient Name _____ Date _____

PATIENT EMAIL AND TEXT COMMUNICATION

FACT SHEET AND INFORMED CONSENT

Carraway Chiropractic Center PLLC uses unencrypted email and text messaging to communicate with our patients.

How we will use Electronic Messaging:

- We may use email for reminders of appointments,
- Actions to take before an appointment, including necessary forms to complete,
- And information about billing, account balances and statements.

Sending Protected Health Information (PHI) by unencrypted email or text exposes a patient's PHI to risks, including but not limited to:

- The email/text message could be captured electronically in transit to or from the patient if not secured.
- The email/text message could be captured electronically when at rest on an unencrypted device.

By signing below, you consent to the use of Electronic Messaging. You are not required to authorize the use of unencrypted mail or text messaging, and a decision not to sign this authorization will not affect your health care in any way. You can choose to stop participating in Electronic Messaging at any time by informing Carraway Chiropractic Center PLLC in writing.

I understand that Carraway Chiropractic Center PLLC will send Electronic Messaging to those email address(es) and telephone number(s) that I designate:

❒ I request to receive email messages at _____
(Your email address)

❒ I request to receive text messages at _____
(Standard message rates may apply. You may opt out at any time by replying STOP)

By signing below, you acknowledge that you have read and fully understand this consent form. By signing below, you also acknowledge your recognition and understanding of the inherent risks of communicating your health information via unencrypted email and text and hereby consent to receive such communications despite those risks.

I agree to hold harmless Carraway Chiropractic Center for unauthorized use, disclosure, or access of my protected health information sent to the email address / text number provided.

_____ Date_____
Signature of Patient or Legally Authorized Person