Whom may we thank for referring you to this office → ________________________________?

APPLICATION FOR CARE AT Raleigh Specific Chiropractic

Today's Date:__________________ HRN: ____________________

PATIENT DEMOGRAPHICS

Name: ____ Birth Date:_____-_____-_____ Age:_______ ☐ Male ☐ Female

Address:______________________________________City:________________________________State:_____Zip: _____________

E-mail Address:__________________________________ Home Phone:_____________________ Work Phone: ____________

Marital Status: ☐ Single ☐ Married Mobile Phone:__________________________ Cell Provider for text reminders:___________

Driver's License #: ______________________________ Do you have Insurance: ☐ Yes ☐ No

Employer:_____________________________________Occupation:____

Spouse's Name______________________________________Spouse's Employer: ______________________________________

Number of children and Ages: ____

Name & Number of Emergency Contact: ______________________________________Relationship: ___________________

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office and rate your complaints by ***circling the number*** on a scale of **1** to **10** with **0** being no pain and **10** being the worst pain.

Primary or chief complaint: _________________________ : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Second complaint: ________________________________ : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third complaint: __________________________________: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Fourth complaint:__________________________________: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin?____________________ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

What relieves your symptoms: ____

What makes them feel worse: ____

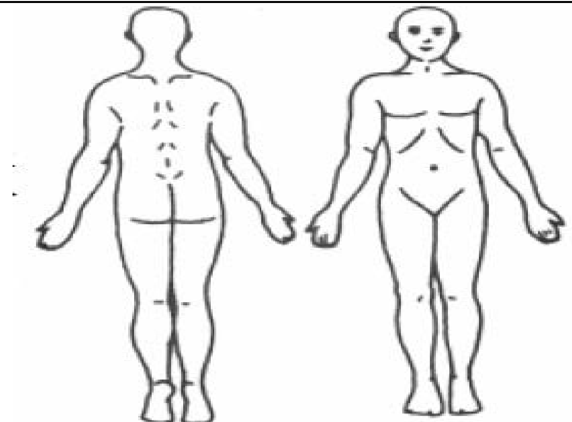
Is your problem the result of ANY type of accident? ☐ Yes ☐ No **How did the injury happen?** _________________________

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when:_________by whom?________________________

How long were you under care:______________ What were the results? ____

Have you seen a Chiropractor in the past?: ☐ Yes ☐ No

If so, who: ______________________________________



***PLEASE MARK** the areas on the diagram with the **following letters** to describe your symptoms:

R = **R**adiating **B** = **B**urning
D = **D**ull **A** = **A**ching
T= **T**ingling **N** = **N**umbness
S = **S**harp/ **S**tabbing

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

____

____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? ______________

When was the last episode? ____

How did the injury happen? ____

Other forms of treatment tried?: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: ______________

Provided by: ______________ How long ago? __________ What were the results? ☐ Favorable ☐ Unfavorable

Please explain. ____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past***, **C** for ***Currently*** have**:**

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Disability ___ Cancer
___ Heart Attack ___ Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions: __________

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

SOCIAL HISTORY

Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ daily ❑ weekends ❑ occasionally ❑ never
Alcoholic Beverage(s): consumption occurs → ❑ daily ❑ weekends ❑ occasionally ❑ never
Recreational Drug(s): ❑ daily ❑ weekends ❑ occasionally ❑ never

FAMILY HISTORY:

Does anyone in your family suffer with the same conditions(s)? ❑ No ❑ Yes
If yes, whom? ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister ❑ brother ❑ son ❑ daughter
Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know
Any other hereditary conditions the doctor should be aware of? ❑ No ❑ Yes: ______________

I hereby authorize payment to be made directly to Raleigh Specific Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Raleigh Specific Chiropractic for any and all services I receive at this office.

______________________________ ______________

Patient or Authorized Person's Signature **Date Completed**

______________________________ ______________

Doctor's Signature **Date Form Reviewed**

Patient's Name: ______________ **HR#:**______________ ___/___/___

Activities of Daily Living/Symptoms/Medications

Patient Name: ________________________________ Date: ______________ File #: ________________

Daily Activities: Effects of Current Conditions on Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Activity				
Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working Out	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

<u>Please mark P for in the Past or C for Currently.</u>

___ Headache
___ Neck Pain
___Jaw Pain/TMJ
___Shoulder Pain
___Upper Back Pain
___Lower Back Pain
___Hip Pain
___Back Curvature
___Scoliosis
___Swollen/Painful joints
___Dizziness
___Loss of Balance
___Fainting
___Double Vision

___Blurred Vision
___Ringing in Ears
___Hearing Loss
___Depression
___Irritable
___Mood Changes
___ADD/ADHD
___Allergies
___Pregnant (Now)
___Frequent Colds/Flu
___Convulsions/Epilepsy
___Tremors
___Chest Pain
___Pain w/ Cough/Sneeze

___Foot or Knee Problems
___Sinus/Drainage Problems
___Skin Problems
___Prostate Problems
___Impotence/Sexual Dysfun.
___Digestive Problems
___Colon Trouble
___Diarrhea/Constipation
___Menopausal Problems
___Menstrual Problems
___PMS
___Bed Wetting
___Learning Disability
___Eating Disorder

___Trouble Sleeping
___Ulcers
___Heartburn
___Heart Problem
___High Blood Pressure
___Low Blood Pressure
___Asthma
___Difficulty Breathing
___Lung Problems
___Kidney Trouble
___Gall Bladder Trouble
___Liver Trouble
___ Hepatitis (A,B,C)

___Numbness/Tingling in arms, hands, fingers
___Numbness/Tingling in legs, feet, toes

List any prescription drugs you take: ____

____

List any non-prescription drugs you take: ____

____

List any supplements you take: ____

____

Initial Nerve System Profile

When was your most recent auto accident? ________________

Type of impact: Front Impact / Side Impact / Rear Impact What speed was the collision? __________________________

Did you receive treatment? Please describe: ____

When was your most recent strain / stress at work? _____________ What type of injury: __________________________________

Did you receive treatment? Please describe: ____

Does your job require you to remain in long term stressful postures? ☐ Yes ☐ No

(i.e. all day sitting, repeated lifting, long term computer use)

Have you had any spinal traumas in the past? ☐ Yes ☐ No Please circle all that apply below:

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field

Traumas as a child: fall on your head, impact to your head, concussion, falls onto your back or tailbone, biking accident

Work around the house: lifting, bending, woke up with stiff neck, “back went out”

Doctor Signature: ____ Date: ____________________ JDD, DC 9/2018

OUR OFFICE POLICIES

Welcome to Raleigh Specific Chiropractic!

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care,*** please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

☐ **PATIENT PRIVACY –** Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at **Raleigh Specific Chiropractic** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to Thompson Drop Table, Diversified, Pro-Adjuster, Impulse Instrument Adjusting and Gonstead. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

☐ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

Note: Patient retains the above Notice of Office Policies and RALEIGH SPECIFIC CHIROPRACTIC retains the signature sheet.

Patient initials:_________-retaining pages 1 of 2

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

____	____________________	____________________
Patient's Name	Date of Birth	File #

____ ____________________
Patient's Signature Date

____ ____________________
Witness Date

Raleigh Specific Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. However, you can purchase them on a CD for $5.00.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Jill Winget at (919) 846-7004. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Raleigh Specific Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACYcontinued….

I have received a copy of Raleigh Specific Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_______________________________ _______________ _______________
Patient's Name Date of Birth File #

_______________________________ _______________
Patient's Signature Date

_______________________________ _______________
Witness Date

JDD,DC 9/2018

I give permission to Drs. James and Jill Winget, their staff, associates, and employees of Raleigh Specific Chiropractic to share private and medical information with the family members listed below.

Name	Relationship

Signature:____Date: ____________________

Chiropractic for pediatric development and adult health

7721 Six Forks Rd.
Suite 138
Raleigh, NC 27615
(919) 846-7004

Informed Consent for Chiropractic Care

Raleigh Specific Chiropractic, Inc

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

______________________________	______________________
Patient Name (printed)	Relationship to patient
______________________________	______________________
Patient Signature (or Legal Guardian)	Date
______________________________	______________________
Witness Signature (office staff)	Date
______________________________	______________________
Reviewed by Doctor	Date