RALEIGH SPECIFIC CHIROPRACTIC

Chiropractic for pediatric development and adult health

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

Items to bring to your *first* visit:

- ❑ All new patient paperwork filled out in advance
- ❑ Your automobile insurance policy
  - o Claim number
  - o Adjuster's name and phone number
  - o Contact your automobile insurance and open a medical claim
- ❑ 3rd party automobile policy information
  - o Claim number
  - o Adjuster's name and phone number
- ❑ Your health insurance
- ❑ Your attorney information, if applicable

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: _____

INSURANCE INFORMATION

At Fault Insurance Information

Company Name: _____ Claims Adjustor's Name: _____

Claim #: _____ Phone #: _____

Address: _____

MedPay Insurance Information

Company Name: _____ Claims Adjustor's Name: _____

Claim #: _____ Phone #: _____

Address: _____

Attorney Information

Company Name: _____ Case Manager's Name: _____

Phone #: _____

Address: _____

Health Insurance Information

This office will verify health insurance coverage for you. This is done as a courtesy for you, so please attach Insurance Card if available, and return to chiropractic assistant with this intake request.

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed? _____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE

(if applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

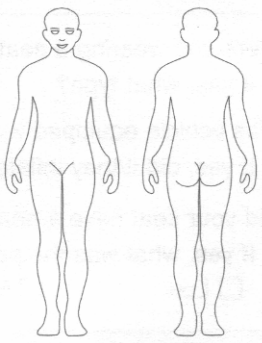
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

NECK OSWESTRY FORM

Please Read: This questionnaire is designed to enable us to understand how much your neck has affected your ability to manage everyday activities. Answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **only circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity
A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading
A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache
A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 -- Concentration
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving
A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping
A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation
A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all.

Patient Name: _____

SIGNATURE:_____ **DATE:**_____

DISABILITY INDEX SCORE: **%**_____

Staff Initials_____

LOW BACK OSWESTRY FORM

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **only circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
D. Washing and dressing increase the pain and I it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3--Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 --Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than ¼ mile.
D. Pain prevents me from walking more than ½ mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than 1/2 hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6 -- Standing

A. I can stand as long as I want without pain
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing pain.
F. I avoid standing because it increases pain right away.

SECTION 7--Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8--Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. Pain prevents me from any social life at all.

SECTION 9--Traveling

A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10--Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

DISABILITY INDEX SCORE: %_____

Patient Name: _____ Date: _____

Staff Initials ____

Roland Morris Disability Index

Name_____ Date ____/____/____ File #_____
(Please Print)

When your back hurts, you may find it difficult to do some of the things you normally do. Check the box before each sentence that describes you today. Leave the box blank if the sentence does not describe you.

- ❑ I stay home most of the time because of my back.
- ❑ I change positions frequently to try and get my back comfortable.
- ❑ I walk more slowly than usual because of my back
- ❑ Because of my back, I am not doing any of the jobs that I usually do around the house.
- ❑ Because of my back, I use a handrail to get upstairs.
- ❑ Because of my back, I lie down to rest more.
- ❑ Because of my back, I have to hold on to something to get out of an easy chair.
- ❑ Because of my back, I try to get other people to do things for me.
- ❑ I get dressed more slowly because of my back.
- ❑ I only stand up for short periods of time because of my back.
- ❑ Because of my back, I try not to bend or kneel.
- ❑ I find it difficult to get out of a chair because of my back.
- ❑ My back is painful almost all of the time.
- ❑ I find it difficult to turn over in bed because of my back.
- ❑ My appétit is not very good because of my back.
- ❑ I have trouble putting on my socks (stockings) because of my back.
- ❑ I only walk short distances because of my back pain.
- ❑ I sleep less well because of my back pain.
- ❑ Because of my back pain, I get dressed with help from someone else.
- ❑ I sit down for most of the day because of my back.
- ❑ I avoid heavy jobs around the house because of my back.
- ❑ Because of my back pain, I am more irritable and bad tempered with people than usual.
- ❑ Because of my back, I go upstairs more slowly than usual.
- ❑ I stay in bed most of the time because of my back.

Form by Roland M, Morris R. Spine 1983;8(2):141-144. Lippincott-Raven Publishers

Raleigh Specific Chiropractic

Chiropractic for pediatric development and adult health

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

Patient Consents

Consent for purposes of treatment, payment and healthcare operations

I consent to the use or disclosure of my protected health information by Raleigh Specific Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Raleigh Specific Chiropractic. I understand that diagnosis or treatment of me by Dr. James Winget or Dr. Jill Winget may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction. Raleigh Specific Chiropractic is not required to agree to the restriction I may request. However, if Raleigh Specific Chiropractic agrees to a restriction that I request, the restriction is binding on Raleigh Specific Chiropractic and on Drs. Winget. I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. James/Jill Winget or Raleigh Specific Chiropractic has taken action in reliance on this consent. More information regarding this consent is available upon request.

Open adjusting area

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. Open adjusting involves several patients being seen in the same adjusting area at the same time. Patients are within sight of one another, and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting. We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kinds of matters related in an open adjusting environment are incidental matters. In the event you are someone else would not agree with us, we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive, as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open adjusting environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from Raleigh Specific Chiropractic or on your relationship with our staff.

Your signature indicates your authorization of this activity. Your authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

Contact

It is our desire for our staff to use your name, address, and/or telephone number for the purpose of contacting you to advise you about health-related meetings, workshops, missed appointments and appointment reminders. The use of this information is intended to make your experience with our office more efficient and productive, as well as to further enhance your access to quality health care. If you choose not to authorize this information use, your decision will have no adverse effect on your care from Raleigh Specific Chiropractic or on your relationship with our staff.

This office also occasionally posts stories and x-rays of current patients. If this situation presents itself in your case, this office will obtain specific permission from you for that purpose.

Your signature indicates your authorization of this activity. Your authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

Patient Name, Printed	Patient Signature	Date

RALEIGH SPECIFIC CHIROPRACTIC

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