Saleeby Chiropractic Centre, P.A.

Stephen M. Saleeby, D.C.
Wayne J. Prickett, D.C.

Chiropractic ONP-New Injury

Today's Date: _____/_____/_____ Z code # _____

Name: _____DOB: ____/_____/___ Age: _____
First MI Last

Sex: □ Male □ Female Email:_____ □Married □ Single □ Other: _____

Address:_____ City:_____ State:_____ Zip:_____

Home # _____-_____-_____ Cell # _____-_____-_____ Work # _____-_____-_____

Do you have health insurance? □Yes □ No Insurance Company: _____

Insured's Name: _____ Insured's DOB _____/ _____/ _____

Your Medical Doctor: _____ Last Exam: _____

Medicines: _____

Surgeries/Procedures: _____

Are you currently pregnant? □Yes □ No

Reason For Your Visit:

□Pain Symptom □ □Wellness Visit □ Auto Accident □□Work Related Injury

□ Sports Injury □ Other Injury**:** _____
Primary Complaint: _____Secondary Complaint: _____
Date of Injury / Onset of Symptoms: _____

Have you recently slept on: your stomach a couch a new bed on the floor a recliner

Have you recently taken a long trip? □ Yes □ No
Duration of trip? _____Mode of transportation _____

3814 Browning Place, Suite102, Raleigh NC 276096521
919-782-4733 Fax 919-783-8225

Your Medical History: (Check all that apply) (*Y: Yourself* *F: Family Member*)

Y F	Y F	Y F	Y F
□ □ Fatigue	□ □ Dizziness / Vertigo	□ □ Fainting	□ □ Cold Hands
□ □ Cold Feet	□ □ Hand Tremors	□ □ Nausea	□ □ Diarrhea
□ □ Constipation	□ □ Varicose Veins	□ □ Stroke	□ □ Difficulty Breathing
□ □ Coughing Blood	□ □ Bleeding	□ □ Sweats	□ □ Pregnancy
□ □ Prostate Problems	□ □ Heart Attack	□ □ Circulatory Problems	□ □ High Blood Pressure
□ □ Low Blood Pressure	□ □ Ulcers	□ □ Heart Problems	□ □ Pacemaker
□ □ Diabetes	□ □ Alzheimer's	□ □ Gallbladder Problems	□ □ Digestive Problems
□ □ Eczema	□ □ Convulsions	□ □ Tumors	□ □ Seizures
□ □ Epilepsy	□ □ Tinnitus	□ □ Headaches	□ □ Migraines
□ □ Eye/Vision Problems	□ □ Ear/hearing problems	□ □ Arthritis	□ □ Osteoarthritis
□ □ Rheumatoid Arthritis	□ □ Osteoporosis	□ □ HIV / AIDS	□ □ Congenital Disease
□ □ Ruptures	□ □ Disc Disorder	□ □ Speech Difficulty	□ □ Loss of Memory
□ □ Confusion	□ □ Nervousness	□ □ Anxiety	□ □ Mental Illness
□ □ Irritability	□ □ Tension	□ □ Depression	□ □ Insomnia
□ □ Eating Disorder	□ □ Alcoholism	□ □ Drug Addiction	□ □ Scoliosis
□ □ Tonsillitis	□ □ Kidney Disorder	□ □ Gout	□ □ Neuralgia
□ □ Chills	□ □ Earache	□ □ Sciatica	□ □ Amputation
□ □ Vomiting	□ □ Hemorrhoids	□ □ Bursitis	□ □ COPD
□ □ Broken / Fractured Bones	□ □ Neuro-Muscular Disease	□ □ Loss of Bladder Control	□ □ Loss of Bowel Control
□ □ Cancer:	□ □ Other:	□ □ Other:	□ □ Other:

Which Activities are difficult due to your Pain / Discomfort?

□ Sleeping	□ Walking	□ Standing	□ Sitting	□ Running
□ Climbing	□ Bathing	□ Showering	□ Dressing	□ Shoes
□ Toileting	□ Cleaning	□ Self Care	□ Family Care	□ Child Care
□ Home Care	□ Driving	□ Gardening	□ Working	□ Lifting
□ Desk Work	□ Traveling	□ School	□ Concentrate	□ Other:

Additional Comments: _____

_____

_____

_____

_____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself—not between my insurance company and this office. I agree to pay my estimated co-pay at the time services are rendered, including my deductibles, and further understand that the estimated co-pay is neither a guarantee of payment by insurance company, nor necessarily an accurate reflection of my co-pay as determined by my insurance company upon processing my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time upon request of this office, I will immediately pay the balance on my account. I further understand and agree that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees. I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney (s) who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my Insurance companies, attorneys, or other payers. I have read, understood, and agree to the foregoing. The information I have provided is true and complete, to the best of my knowledge.

_____

Signature **Printed Name** **Date**

3814 Browning Place, Suite102, Raleigh NC 276096521
919-782-4733 Fax 919-783-8225

NEW PATIENT HISTORY FORM

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

3814 Browning Place, Suite102, Raleigh NC 276096521
919-782-4733 Fax 919-783-8225

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

3814 Browning Place, Suite102, Raleigh NC 276096521
919-782-4733 Fax 919-783-8225