Cleveland Chiropractic
5638 NC 42 W Suite 204
Garner, NC 27529

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: ____________________ **Last Name:** ____________________

Email address: ______________________________@__________________

DOB: ___/___/_____ **Gender (Circle one):** Male / Female **Preferred Language:** ____________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): ____________

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Patient Signature: ______________________________ Date: ____________

For office use only

Height: ________ Weight: ________ Blood Pressure: _______/________ Pulse: ________

PERSONAL HEALTH HISTORY

Cleveland Chiropractic & Massage   Dr. Michelle Elliott   5638 NC Highway 42W Ste. 204   Garner, NC 27529   919-772-7996

Personal

Name: 1st_______________MI____ Last_____________________ SS# _____-____-_____ Date ___/___/___

Address: ___________________________________ Bday:____/____/____ Age:______ Sex: __M __F

City/State/Zip ___________________________________ Chief Complaint: ___________________________

Employer: ___________________________________ Type of Work: ___________________________

Marital Status __________ Name & ages of children ____

Phone

Home #: _____-______-________ Work #: _____-______-________ Mobile #: _____-______-________

Other #: _____-______-________ E Mail : ________________________ (optional)

Insurance **(or give us your insurance card to copy)**

Ins. Co.: _____________________ Ins. Plan:___________________ Insured's name: ________________

Ins. ID#: _____________________ Ins. Grp.#: __________________ Insured's S.S.#: _____-____-______

Insured's DOB: ____/____/_____. Ins Ph. #: 1-800-______-________

Spouse

Spouse Name _________________ Employer ____________________ Spouse's Bday _____/_____/_____

Spouse S.S.# _____-_____-______ Work # : ____-______-________ Mobile # : ______-_____-_______

General

How were you referred to our office? ____

Emergency Contact: Name______________________ Phone # ____-_____-______ Relationship: _________

Your Medical Doctor: Name______________________ Phone #____-_____ -______ Town: _______________

Who Is Responsible for Your Bill…? You and…. …. ☐ Spouse, ☐ Health Insurance, ☐ Auto Insurance,

☐ Medicare, ☐ Medicaid, ☐ Worker's Comp., ☐ Other Explain: ______________________________

Is your condition due to an auto accident or work injury? Y / N, If yes, when? ____________________

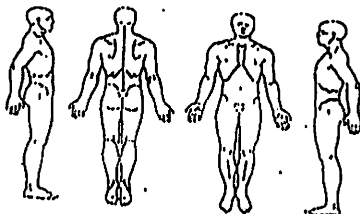
CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Tuberculosis
- ☐ Anemia
- ☐ Diabetes
- ☐ **Cancer**/Tumors
- ☐ Kidney problem
- ☐ Liver problems
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Osteo-Arthritis
- ☐ Epilepsy
- ☐ Allergies
- ☐ Asthma
- ☐ Lung Problems
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Sexual disease
- ☐ Systemic Lupus
- ☐ Meningitis
- ☐ Psychiatric disorder
- ☐ Multiple Sclerosis
- ☐ Fibromyalgia
- ☐ **Strokes** / Passing out
- ☐ High / Low Blood Pressure
- ☐ Rheumatoid-Arthritis

INTAKE:

- ☐ White Sugar
- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes

MARK YOUR AREAS OF PAIN:



Initial Consultation / Current Health Condition

Cleveland Chiropractic & Massage, Dr. Michelle Elliott, 5368 NC Highway 42 W Garner, NC 27529 919-772-7996 PH

PATIENT NAME: ____________________________ Chart # _____________ **DATE** ___/___/___.

PLEASE FILL OUT OR CIRCLE EACH AND EVERY LINE AND QUESTION COMPLETELY

What are your symptoms **TODAY?** ____________________________ **SIDE?** Right / Left / Both / Center
(Why are you here / What hurts)

WHEN did it start? ____________________________ Is it getting ____**Better** ____**Worse** ____ **Same**

HOW did it start? ____________________________ Where does it **RADIATE?** ____________________________

What makes it **BETTER?** ____________________________ What makes it **WORSE?** ____________________________

Has this happened **BEFORE?** Yes / No Explain: ____________________________

How **FREQUENT** is the pain? ___ Occasional ___ Often ___ Constant How **SEVERE** is the pain? 1 2 3 4 5 6 7 8 9 10

WHAT ARE YOUR WORK ACTIVITIES?

____

What **ACTIVITIES** hurt? ____________________________ Describe your **STRESS level?** ☐ low ☐ medium ☐ high ☐ very high

DESCRIBE the PAIN: stiff sore burning dull aching sharp shooting numb tingling stabbing gnawing tight tender
(circle *all* that apply)
Other : Please ***explain*** ____________________________

WHEN is it at its WORST: early AM late AM afternoon evening night ***Explain:*** ____________________________
(circle all that apply)

WHEN is it at its **BEST**: early AM late AM afternoon evening night ***Explain:*** ____________________________
(circle all that apply)

WHAT makes it **WORSE**: lay sit stand walk turn bend forward / backwards Other: ____________________________
(circle all that apply)

WHAT makes it **BETTER**: lay sit stand walk turn bend forward / backwards Other: ____________________________
(circle all that apply)

MD's seen for this : ____________________________ ***Results*** : ____________________________

CHIROPRACTORS seen before: ____________________________ Results: ____________________________

Do you or have you ever had: **A Stroke Cancer Diabetes Heart Disease Lung Disease** ***Other:*** ____________________________
(circle all that apply)
Explain : ____________________________

List All SURGERIES: Head Brain Heart Lung Neck Back Shoulder Arm Hand Hip Leg Foot Other: _____________ (circle all that apply)
Results : ____________________________

In the ***Past Year*** have you...Been in the **HOSPITAL?** Yes / No ***Explain:*** ____________________________

In the ***Past Year*** have you...Had any **Major INFECTIONS?** Yes / No ***Explain:*** ____________________________

Do you get **DIZZY / PASS OUT** have history of **STROKES?** Yes / No ***Explain:*** ____________________________

What **Major TRAUMAS** have you had in your lifetime? ____________________________
(include ***any and all*** accidents, falls and injuries)

____

List **All MEDICATIONS AND ILLNESSES:** ____________________________

____

List **OTHER HEALTH PROBLEMS:** ____________________________
Doctor's Notes: ____________________________

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________________ **Date** ____________

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck Index Score ____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________________ **Date** ______________

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back Index Score ______

CLEVELAND CHIROPRACTIC AND MASSAGE

5638 NC 42W #204, Garner, NC 27529 (919)-772-7996-PH

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of any and all diagnostic procedures and therapeutic modalities including chiropractic adjustments and procedures, various modes of physio-therapy, examination and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible). This applies to the Doctor of Chiropractic and staff of the office named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working with, or associated with, or serving as back-up for the doctor of chiropractic named above, including those working at other Cleveland Chiropractic and Massage offices. I also give my permission for this office to release records of my treatment to my primary care physician for purposes of coordinating care.

I have had an opportunity to discuss with the Doctor of Chiropractic named below 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 with the practice of medicine, chiropractic carries some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I acknowledge that any and all services provided to me by this clinic remain my sole financial obligation and that any insurance or other third-party payment arrangements remain an agreement between myself and my insurer (including Medicare) or other responsible party. I also give permission to this office to release any and all records, x-rays or personal information regarding my condition to any and all insurers (including Medicare and Medicaid), healthcare providers, my employers, attorneys, etc. deemed appropriate for paying, providing healthcare, employment, legal advise or otherwise associated with my case in order to assist this office in its service to me and / or in the processing of my account. I also give permission to Medicare / Medicaid to release any and all information to 3rd party and / or secondary insurers associated with my case.

I hereby grant an assignment of insurance benefits to be paid directly to this office. I acknowledge that I am financially responsible for all non-covered services. I also understand that if I terminate my care and treatment, any fees for professional services rendered me will also be due and payable immediately.

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

A photocopy of this assignment shall be considered as effective and valid as the original.

To be completed by the patient.	**To be completed by patient's representatives.** If patient is a minor or is physically or mentally incapacitated
______________________________ Patient's Printed Name - seal	______________________________ Patient Representative's Printed Name - seal
______________________________ Signature of Patient - seal Date	______________________________ Signature of Patient's Representative - seal Date

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

OUR PRIVACY PLEDGE

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and as a means of communication among many health care professionals who contribute to your care. It is also a legal document that describes the care you received as well as a means by which you or a third party payer can verify that services billed were actually provided. It is a tool with which we can access and continually work to improve the care we render and the outcomes we achieve. Understanding what is in your record and how your health information is used helps you to ensure its accuracy and better understand who, what, when, where, and why others may access your health information. It also helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of the healthcare practitioner that compiled it, the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information. This includes the right to obtain a paper copy of the notice of information practices upon request, and also to inspect, and obtain, a copy of your health record. If you would like to exercise your right to a copy of your file, please call our office to schedule an appointment.

You have the right to request an accounting of disclosures of your health information and you have the right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES:

This office is required to maintain the privacy of your health insurance information and provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. The office will abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, and accommodate reasonable requests you may have to communicate health information by alternative means. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail you a revised notice to the address you've supplied us. We will not use or disclose your health information without your authorization, except as described in this notice.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS:

We will use your health information for treatment. For example: Information obtained by our chiropractor, or any other member of our healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. We will also disclose information from your medical record to specialists to whom you are referred in order to assist them in establishing a plan of care for you.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you as well as your diagnosis, procedures, and supplies used.

Business associates: There are some services provided in our office through contacts with business associates. Examples include our use of third party billing facilities. We will disclose health information that identifies you, your diagnosis and any treatment provided to you in our facility. To protect your health information, however, we require the business associate to safeguard your information.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Appointments / Marketing: We may contact you either at home or at work by phone, fax or mail to provide you with appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. If contact is made by phone and you are not available, a message may be left on your answering machine, voice mail, or with the person answering the phone.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Attorneys: If you have retained an attorney as a result of an injury or an accident, we may disclose health information that includes your diagnosis and any treatment provided to you at this facility as well as any doctor's notes.

OTHER IMPORTANT INFORMATION:

When you arrive, our staff will ask you to sign in on our sign in sheet. This verifies that you were in our office on that date, should a question ever arise. Please note that by doing this, you allow other patients to know you were here. If you prefer **NOT** to sign in on this sheet, please notify us immediately.

We also utilize a referral board and testimonial book in our waiting room. It is our way of saying thank you for trusting us enough to refer your friends and family. If you prefer your name **NOT** to be listed on this board, please notify us immediately.

HEALTH CARE AUTHORIZATION:

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your information before we receive your request to revoke your authorization.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have any questions or concerns or you believe your privacy rights have been violated, you can contact our director of health information management at 919-772-7996 for assistance.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (section 164.520)

You have the right to inspect or copy the information that we use to contact you for appointment reminders, information about treatment alternatives, or other health related information at any time.

- This notice is effective as of the date below
- This notice will expire seven years after the date upon which the record was created.
- I have read your authorization and agree to the terms.
- My signature authorizes you to disclose my private health information in the manner described above and acknowledges that I will receive a copy of the completed form for my own records with written request.

__________________________	________________________	________
NAME (PLEASE PRINT)	SIGNATURE	DATE

If you are a minor, or are being represented by a third party:

__________________________	________________________	________
PERSONAL REPRESENTATIVE (PRINT)	SIGNATURE	DATE

Description of the authority to act on behalf of the patient (relationship, power of attorney):

____

____