CONFIDENTIAL HEALTH INFORMATION Disc and Neuropathy Patients

Select Health of the Carolinas at The Disc Institute 15830 Ballantyne Medical Place Suite #250 Charlotte, NC 28277 704-541-5555

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Please allow our staff to photocopy your drivers license and insurance details. All information you supply is confidential. We comply with Federal privacy standards. **Please Complete ALL Information and Print Clearly.**

Todays Date (MM/DD/YYYY)				F	Patient	Number (office use only)
How were you referred to the office?						
Age Gender O Male O Fer		○ Nativ	re Hawaiian O Other Pacific Isla	○ Asian ○ Black or African Ar ander ○ Other ○ White	merican	Ethnicity Hispanic or Latino Not Hispanic or Latino
Birth Date (MM/DD/YYYY)		O Decli	ine to answer			○ Decline to specify
Your Last Name		So	cial Security Number	Smoking Status (age 1 Never A Smoker O Form Current Every Day Smoker	er Smoke	
Your First Name		Yo	ur Middle Name (Initial)	$^ \bigcirc$ Heavy Smoker \bigcirc Light S	moker	
Address (Including Unit or Apartment	Number)			Marital Status Married		
City	State/Provi	nce	ZIP/Postal Code	─ ○ Widowed ○ Separated	Pref	erred Language
Home Phone	Cell Phone			Spouse's Name		
Email Address				Child's Name and Age	}	
Emergency Contact	Emergency	Conta	act's Phone	Child's Name and Age	<u>}</u>	
Your Occupation				Child's Name and Age	}	8
Your Employer				Work Phone		— Ž
Address				May we contact you at ○ Yes ○ No	t work?	
City	State/Provi	nce	ZIP/Postal Code	- Preferred method of c O Home Phone O Cell Pho		? TIAL
Your Primary Care Provider's Name				\bigcirc Work Phone \bigcirc Email		ΗĘ
Insurance Carrier			-			ALT
Insured's Last Name			Birth Date (MM/DD/YYY	Y)		Ĭ
Insured's First Name	Insured's N	liddle	Name (or Initial)	_		ORN
Who carries this policy? OSelf OSp	oouse O Parent					EALTH INFORMATION

Please describe, in order of importance, the health problems you most interested in getting corrected:

And is the result of (darken circle): A		(complaint) rompted me to seek care	(2) Secondary Concer The secondary symptom that today is:	prompted me to seek care	e The additional s	al Concern (compl ymptom that prompted r	me to seek care	Location: (Where does it hurt?) Circle the area(s) on the illustration. "0" for current condition "X" for conditions experienced in the recent past
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G. SKIN Had Have Had Have Had Have Had Have Had Have Had Have NONE O O Skin cancer O O Psoriasis O O Eczema O O Acne O O Hair loss O O Rash	 4) Have your sym 5) Describe the synch Heavy feelin 6) Do the sympto Sleep Work REVIEW OF SYSTEM Please darken the cirred A. MUSCULOSKELE Had Have Osteoporosis Knee injuries B. NEUROLOGICAL Had Have Hand Numbness C. CARDIOVASCULAR Had Have Had Have Osteoporosine D. RESPIRATORY Had Have Ashma E. DIGESTIVE Had Have Anorexia/bulimia F. SENSORY Had Have Osteoporosine Burred vision 	ptoms: mptoms? (Circle g Hot feeling Tr ms interfere with ork Daily Activitie AS: Cle beside any condi TAL Had Have O Arthritis O Foot/ankle pain Plantar Fasciitis Had Have O Foot Numbness R Had Have O Apnea Had Have O Ullcer Had Have	Improved Wo those that Apply): Ache robbing Dead feeling C any of these? (Circle those on that you've Had or current Had Hi O Scoliosis O and Have Had Hi O Headache O Had Have Had Hi O High cholesterol O Had Have Had Hi O Food sensitivities O Had Have Had Hi	rsened Stabbing Shar Stabbing Shar Cold hands/feet C are that Apply): g Standing Shar ently Have and initia ave Had I Neck pain O Hand/wrist pain O Hand/wrist pain O Dizziness O ave Had I Poor circulation/ O Vascular Issues ave Had I O Hay fever O Had I Hay fever O Had I Had I Hay fever O Had I Had I Hay fever O	ayed the Same p Tiredness Cramping Swel copping Recre al to the right. Back pain (O TMJ issues (Have Hi O Pins and (needles Have Hi O Angina (Have Hi O Constipation (Have Hi	Numbness Ting ling Burning E eational Activities ad Have	NONE O Initials NONE O Initials NONE O Initials NONE O Initials NONE O Initials NONE O Initials NONE O Initials NONE O	Needles like Patient Name Patient Number (office use only)

(Continued from previous page)

H. ENDOCRINE Had Have O O Thyroid issues	Had Have O O Immune disorders	Had Have O O Hypoglycemia	Had Have O O Frequent infection	Had Have Had Have Swollen glands O Low energy	NONE O Patient name
Had Have Kidney stones J. GENERAL	Had Have O O Infertility	Had Have O O Bedwetting	Had Have O O Prostate issues	Had Have Had Have s O Erectile O PMS symptoms dysfunction	NONE O Patient Number Initials (office use only)
Had Have	Had Have O O Fever	Had Have O O Poor appetite	Had Have	Had Have Had Have Sudden weight O Weakness gain/loss (circle one)	NONE O All other systems negative

Past Personal, Family and Social History Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

	 Illnesses Check the illnesses you have Had in the past or Have now. 	5. Operations Surgical interventions, which may or 6. Treatments/MEDICATIONS Check the ones you've received in t	
	Had Have Had Have	may not have included hospitalization. Past or are receiving Currently .	
DNAL	AlDS Tuberculosis Allergies Typhoid fever Allergies Ulcer Arteriosclerosis Other: Cancer Othicken pox Chicken pox 7. Allergies Diabetes Are you allergic to any medications? Epilepsy Yes Gaucoma It Yes please list: Gout Gout	Appendix removal Past Currently Bypass surgery Acupuncture Cancer Antibiotics Cosmetic surgery Birth control pills Elective surgery: Blood transfusion Eye surgery Chiropractic care Hysterectomy Dialysis Pacemaker Herbs Spine Homeopathy	ns
PERSONAL	O Heart disease O Hepatitis O HIV Positive O Malaria O Measles O Multiple Sclerosis	Foot Surgery Inhaler Vasectomy Massage therapy Other: Medications (Please list below ALL PRESCIPTION over-the-counter, natural supplements, enzym vitamins and minerals):	NS,
	 Mumps Polio Rheumatic fever Scarlet fever Sexually transmitted disease Stroke Been knocked unconscion Been injured in an accide 	order O Used neck or back bracing us nt Do you take any other supplem and/or natural product(s) for blood pre-	essure
	amily History	regulation or erectile dysfunction? <i>C</i> YES or NO	JIrcie:

ome health issues are hereditary. **Tell** about the health of your immediate family members.

	Relative	Age (If living)	State of health Good Poor	Illnesses	Age at death	Cause of death
	Mother		\bigcirc \bigcirc			0 0
≻	Father		$\bigcirc \bigcirc$			\circ \circ
MIL	Sister 1		$\bigcirc \bigcirc$			\circ \circ
FAN	Sister 2		$\bigcirc \bigcirc$			\circ \circ
	Brother 1		$\bigcirc \bigcirc$			\circ \circ
	Brother 2		$\bigcirc \bigcirc$			\circ \circ
			$\circ \circ$			$\circ \circ$

10. List ALL allergies/sensitivities to medications, food, and other items here:

11. Social History Tell about your health habits and stress levels.

Alcohol use	○ Daily	OWeekly	How much?			
Coffee use	○ Daily	OWeekly	How much?			
Tobacco use	○ Daily	OWeekly	How much?			
Exercising	○ Daily	OWeekly	How much?			
Pain relievers	○ Daily	OWeekly	How much?			
Soft drinks	○ Daily	○ Weekly	How much?			
Water intake	○ Daily	○ Weekly	How much?			
Hobbies:						
	Coffee use Tobacco use Exercising Pain relievers Soft drinks Water intake	Coffee useO DailyTobacco useO DailyExercisingO DailyPain relieversO DailySoft drinksO DailyWater intakeO Daily	Coffee useDailyWeeklyTobacco useDailyWeeklyExercisingDailyWeeklyPain relieversDailyWeeklySoft drinksDailyWeeklyWater intakeDailyWeekly	Coffee use O Daily O Weekly How much?	Coffee use O Daily Weekly How much?	Coffee use O Daily O Weekly How much? Tobacco use O Daily O Weekly How much? Exercising O Daily O Weekly How much? Pain relievers O Daily O Weekly How much? Soft drinks O Daily O Weekly How much? Water intake O Daily O Weekly How much?



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12. Activities of Daily Living How does this condition currently interfere with your life and ability to function?

0:#:		No Effect	Mild Effect	Moderate Effect	Severe Effect	0	No Effect	Mild Effect	Moderate Effect	Severe Effect	Patient name
-	of chair —				_0	Grocery shopping				_0	Patient Number
-		-			_0	Household chores —	0			_0	(office use only)
-		~				Lifting objects	-			_0	
-		-		_0_	_0	Reaching overhead				_0	
	n <u></u>	-	_0_	_0_	_0	Showering or bathing ——	-	_0_		_0	
-	ver	-	_0_		_0	Dressing myself	-	_0_		_0	
-	stairs ———	-	_0_		_0	Love life —	0	_0_		_0	
-	mputer —	-			_0	Getting to sleep				_0	
-	out of car ————	-			_0	Staying asleep	-				
Ū.	ar ———	-			-0	Concentrating				_0	
-	ver shoulder ———	-	-	_0_	—0	Exercising	0	_0_		—0	
Caring for	family —		_0_	_0_	—0	Yard work ————	O	-0-	—O—	$-\!$	
											—— Consultation Notes
To set clea		s, improve				d help you get the best ht and initial your agree					
Initials	, ,		,	,		describes how my personal he involved third parties.	ealth informatio	on is prot	ected and		
Initials	I grant permission information to me a					ppointment and to be sent occa	asional cards,	letters, e	mails or he	alth	
Initials	I acknowledge that payment of any co	•	-		-	ent between the carrier and me	and that I am	responsi	ble for the		
Initials	To the best of my a or cause of my hea	-		n I have su	pplied is c	omplete and truthful. I have no	t misrepresent	ed the pr	resence, se	verity	
Initials	liable under a contr	ract to the cl mited to, ho	linic or to spital or ı	the patient medical ser	t, family m rvice comp	y part of my record to any perso ember, or employer of the patie panies, physicians' offices or fa yer.	ent for all or pa	art of the	clinic's cha	rge,	
Initials	possible positive o are right for your c	utcomes. W ase. If your	Ve are co case is a	mmitted to accepted, a	helping yo treatment	ery patient is unique and evalua ou understand your true proble t plan will be made for your cor reatment Plans Are Customize	m and determinisideration, if a	ining if th In outside	ese proced		Doctor's Initials

