CONFIDENTIAL HEALTH INFORMATION

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

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)

Patient Number (office use only)

How were you referred to the office?

Age

Gender
◯ Male ◯ Female

Race
◯ American Indian ◯ Alaskan Native ◯ Asian ◯ Black or African American
◯ Native Hawaiian ◯ Other Pacific Islander ◯ Other ◯ White
◯ Decline to answer

Ethnicity
◯ Hispanic or Latino
◯ Not Hispanic or Latino
◯ Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Social Security Number - -

Smoking Status (age 13 and over)
◯ Never A Smoker ◯ Former Smoker
◯ Current Every Day Smoker
◯ Heavy Smoker ◯ Light Smoker

Your First Name

Your Middle Name (Initial)

Address (Including Unit or Apartment Number)

Marital Status ◯ Married
◯ Single ◯ Divorced
◯ Widowed ◯ Separated

City | **State/Province** | **ZIP/Postal Code** | **Preferred Language**

Home Phone | **Cell Phone** | **Spouse's Name**

Email Address | **Child's Name and Age**

Emergency Contact | **Emergency Contact's Phone** | **Child's Name and Age**

Your Occupation | **Child's Name and Age**

Your Employer | **Work Phone**

Address

May we contact you at work?
◯ Yes ◯ No

City | **State/Province** | **ZIP/Postal Code**

Preferred method of contact?
◯ Home Phone ◯ Cell Phone
◯ Work Phone ◯ Email

Your Primary Care Provider's (Your Doctor's) Name

Insurance Carrier

Insured's Last Name | **Birth Date** (MM/DD/YYYY)

Insured's First Name | **Insured's Middle Name (or Initial)**

Who carries this policy? ◯ Self ◯ Spouse ◯ Parent

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

(1) Primary Concern (complaint)
The primary symptom that prompted me to seek care today is: _____

And is the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____

◯ A worsening long-term problem / illness

ONSET (How long have you had this problem?) _____

Prior interventions (What have you done to relieve the symptom?)
◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other _____

(2) Secondary Concern (complaint)
The secondary symptom that prompted me to seek care today is: _____

And is the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____

◯ A worsening long-term problem / illness

ONSET (How long have you had this problem?) _____

Prior interventions (What have you done to relieve the symptom?)
◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other _____

(3) Additional Concern (complaint)
The additional symptom that prompted me to seek care today is: _____

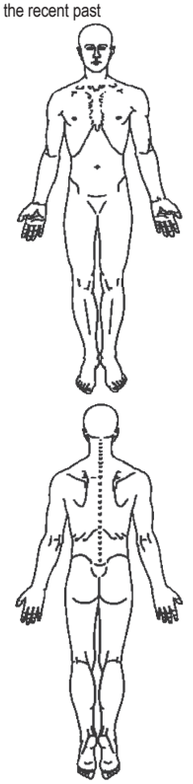
And is the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____

◯ A worsening long-term problem / illness

ONSET (How long have you had this problem?) _____

Prior interventions (What have you done to relieve the symptom?)
◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other _____

Location:
(Where does it hurt?) Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the recent past



→ If you listed medications, for any of your concerns above, please circle which, if any: ←
Gabapentin Neurontin Lyrica Cymbalta Metanx Aleve Tylenol Ibuprofen Motrin Injections Creams

1) **Is your balance/walking being affected by these problems:** ☐YES ☐NO If YES, describe: _____
2) **What do you think is causing your problems?** _____
3) **Is there a certain *PART OF THE DAY* that these problems are better or worse?** Better: _____ Worse: _____
List things that make your condition BETTER: _____
List things that make your condition WORSE: _____
4) **Have your symptoms:** ☐ Improved ☐ Worsened ☐ Stayed the Same
5) **Describe the symptoms?** *(Circle those that Apply)*: Ache Stabbing Sharp Tiredness Numbness Tingling Pins & Needles Heavy feeling Hot feeling Throbbing Dead feeling Cold hands/feet Cramping Swelling Burning Electric Shock-like
6) **Do the symptoms interfere with any of these?** *(Circle those that Apply)*:
Sleep Work Daily Activities Housework Walking Standing Shopping Recreational Activities

REVIEW OF SYSTEMS:
Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

A. MUSCULOSKELETAL

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back pain	◯	◯	Hip/Leg pain
◯	◯	Knee injuries	◯	◯	Foot/ankle pain Plantar Fasciitis	◯	◯	Shoulder problems	◯	◯	Hand/wrist pain	◯	◯	TMJ issues	◯	◯	Joint Replacement

NONE ◯ Initials ____

B. NEUROLOGICAL

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Hand Numbness	◯	◯	Foot Numbness	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Depression and/or Anxiety

NONE ◯ Initials ____

C. CARDIOVASCULAR

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation/ Vascular Issues	◯	◯	Angina	◯	◯	Excessive bruising

NONE ◯ Initials ____

D. RESPIRATORY

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia

NONE ◯ Initials ____

E. DIGESTIVE

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea

NONE ◯ Initials ____

F. SENSORY

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste

NONE ◯ Initials ____

G. SKIN

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash

NONE ◯ Initials ____

Patient Name _____

Patient Number **(office use only)** _____

Providers Initials _____

(Continued from previous page)

H. ENDOCRINE

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○ ○	Low energy	Initials ____

I. GENITOURINARY

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○ ○	PMS symptoms	Initials ____

J. GENERAL

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Fainting	○	○	Fever	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○ ○	Weakness	Initials ____

Patient name _____

Patient Number (office use only) _____

○ 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.

PERSONAL

4. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

7. Allergies

Are you allergic to any medications?

Yes ○ No ○ If Yes please list: _____

8. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing

5. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Foot Surgery
- ○ Vasectomy
- ○ Other: _____

6. Treatments/MEDICATIONS

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Medications

(Please list below **ALL PRESCIPTIONS,** over-the-counter, natural supplements, enzymes, vitamins and minerals): _____

↳ Do you take any other supplements and/or natural product(s) for blood pressure regulation or erectile dysfunction? *Circle:* YES or NO

Consultation Notes

9. Family History

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

FAMILY

Relative	Age (If living)	State of health Good	Poor	Illnesses	Age at death	Cause of death Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
		○	○			○	○

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

_____

11. Social History

Tell about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much? _____
Coffee use	○ Daily	○ Weekly	How much? _____
Tobacco use	○ Daily	○ Weekly	How much? _____
Exercising	○ Daily	○ Weekly	How much? _____
Pain relievers	○ Daily	○ Weekly	How much? _____
Soft drinks	○ Daily	○ Weekly	How much? _____
Water intake	○ Daily	○ Weekly	How much? _____

Hobbies: _____

Doctor's Initials _____

12. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

Overall, how would you rate your pain in the **LAST WEEK**? *NO PAIN* **0 1 2 3 4 5 6 7 8 9 10** *WORST POSSIBLE PAIN*

If you **had to accept *SOME LEVEL*** of pain after completion of treatment, what would be the maximum ***ACCEPTABLE*** level? *PAIN FREE* **0 1 2 3 4 5 6 7 8 9 10** *WORST POSSIBLE PAIN*

Patient name

Patient Number
(office use only)

Consultation Notes

Acknowledgements:

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Initials_____ I further authorize him/her to obtain and/or disclose all or any part of my record to any person or corporation which is or may be liable under a contract to the clinic or to the patient, family member, or employer of the patient for all or part of the clinic's charge, including, but not limited to, hospital or medical service companies, physicians' offices or facilities, insurance carriers, workers compensation carriers, welfare funds, or the patient's employer.

Initials_____ You may or may not be a candidate for our treatment(s). Every patient is unique and evaluated according to the severity and possible positive outcomes. We are committed to helping you understand your true problem and determining if these procedures are right for your case. If your case is accepted, a treatment plan will be made for your consideration, if an outside referral is in your best interest, it will be handled in a timely manner. All Treatment Plans Are Customized For Each Individual.

Doctor's Initials

Patient (or Guardian's) signature

Date (MM/DD/YYYY)