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

CONFIDENTIAL HEALTH INFORMATION

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 (or how did you hear about) the office?

Age

______ / ______ / _______
Birth Date (MM/DD/YYYY)

Your Gender:
○ Male ○ Female OR Other : ____________________

Your Last Name

Social Security Number - -

Your First Name

Your Middle Name (Initial)

Street Address (Including Unit or Apartment Number)

Marital Status ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated

Spouse's Name:

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

Home Phone | **Cell Phone**

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

Email Address

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

Your Occupation

Your Employer

Work Phone

Address

May we contact you at work?
○ Yes ○ No

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

Health Insurance Company Name

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 problem(s) you are most interested in correcting:

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

____
____
____
____

ONSET (When did this problem start?) ____________________

Prior interventions (What have you done to relieve the symptoms?)

- ◯ Prescription medication
- ◯ Acupuncture
- ◯ Over-the-counter drugs
- ◯ Massage
- ◯ Homeopathic remedies
- ◯ Ice
- ◯ Physical therapy
- ◯ Heat
- ◯ Surgery
- ◯ Other ____________________

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

____
____
____
____

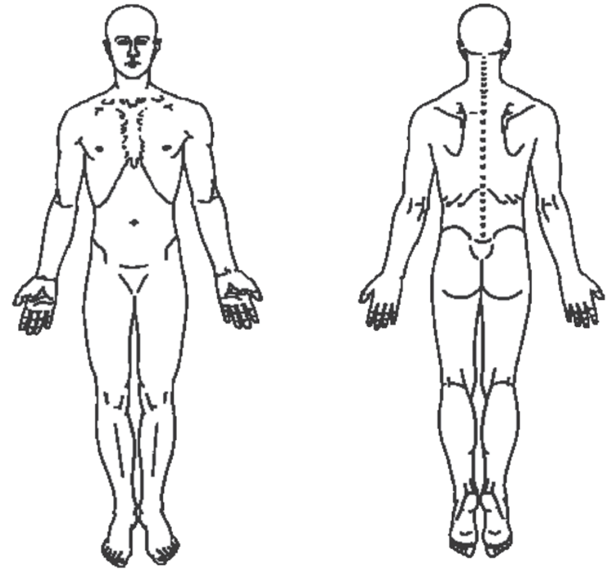
ONSET (When did this problem start?) ____________________

Prior interventions (What have you done to relieve the symptoms?)

- ◯ Prescription medication
- ◯ Acupuncture
- ◯ Over-the-counter drugs
- ◯ Massage
- ◯ Homeopathic remedies
- ◯ Ice
- ◯ Physical therapy
- ◯ Heat
- ◯ Surgery
- ◯ Other ____________________

Location (Where are your symptoms?)
Mark the area(s) on the illustrations.

"X" for current condition



Please Tell Us:

If you listed prescription or over the counter medications above, please *circle* which, if any:

Gabapentin (Neurontin) Lyrica Cymbalta Metanx Aleve Tylenol Ibuprofen Injections Creams None Listed

Is your balance/walking being affected by these problems? ❑ Yes ❑ No If Yes, please describe:____________________

What do you think is the *underlying* cause of your current health condition(s)?: ____________________

Since you've had this issue, have your symptoms?: ❑ Improved ❑ Worsened ❑ Stayed the Same

Describe your symptoms: ***(Circle all those that apply):***

Ache Stabbing Sharp Tiredness Numbness Tingling Pins and Needles Heavy Feeling Hot Feeling
Throbbing Dead Feeling Cold Hands/Feet Cramping Swelling Burning Electric Shock-like

Please place a check beside any condition/symptom that you've *HAD* or currently *HAVE* :

Past	Now		Past	Now		Past	Now	
____	____	Osteoporosis	____	____	Foot/Ankle pain	____	____	Hand numbness
____	____	Arthritis	____	____	Plantar Fascitis	____	____	Foot numbness
____	____	Scoliosis	____	____	Shoulder problems	____	____	Headache(s)
____	____	Neck pain	____	____	Hand pain	____	____	Dizziness
____	____	Back pain	____	____	Wrist pain	____	____	Pins & Needles
____	____	Hip/Leg pain	____	____	Joint Replacement	____	____	Depression
____	____	Knee Injuries	____	____	TMJ issues	____	____	Anxiety

____
Patient Name

____
Patient Number
(office use only)

____
Providers Initials

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Please place a check beside any illness that you've *HAD* or currently *HAVE* :

Past	Now		Past	Now		Past	Now	
____	____	AIDS	____	____	Goiter	____	____	Polio
____	____	Alcoholism	____	____	Gout	____	____	Rheumatic Fever
____	____	Allergies	____	____	Heart Disease	____	____	Scarlet Fever
____	____	Arteriosclerosis	____	____	Hepatitis	____	____	Sexually Transmitted Disease
____	____	Cancer	____	____	HIV Positive	____	____	Stroke
____	____	Chicken Pox	____	____	Malaria	____	____	Tuberculosis
____	____	Diabetes	____	____	Measles	____	____	Typhoid Fever
____	____	Epilepsy	____	____	Multiple Sclerosis	____	____	Ulcer
____	____	Glaucoma	____	____	Mumps	____	____	Other ______________________

Please answer the following, *and initial* in the space beside your answer.

Do you have, or have you ever had, ANY surgically implanted device (*including, but not limited to, pacemakers*)?

YES NO Initials: _______

If Yes, provide device details: ____

____

____

Overall, how would you rate your pain or other symptoms over the last month? (0 = None 10 = Worst Possible)

0 1 2 3 4 5 6 7 8 9 10

Acknowledgements:

To set clear expectations, meet federal guidelines, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial in each line provided.

Initials __________ I understand that should I pursue treatment beyond this initial consultation, the completion of additional health history documentation will be required of me, in order to fulfill requirements set forth by both state and federal guidelines.

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.

____
Patient name

____
Patient Number
(office use only)

____
Doctor's Initials

By affixing my signature below, I am attesting that the information I have provided in this Confidential Health Information is accurate to the best of my knowledge.

______________________________________ ______________________

Patient (or Guardian's) signature Date (MM/DD/YYYY)

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