#_____

Daniel Keadle DC, Brian Ransone DC
7116 Six Forks Road • Suite A • Raleigh, NC 27615

Referred by: _____

NAME _____ DOB _____ Employer_____

OVERALL HEALTH

- How would you rate your stress levels? (0= no stress, 10= high stress) _____
- Do you exercise? _____ How often? _____ What activity? _____
- Are you currently under another physician's care? _____ If so, for what?

_____

- Please list any surgeries you've had.

_____

- Have you seen a chiropractor before? _____ If so, when? _____
- Please list any accidents or traumas you've had.

_____

- Do you have a pace maker or any other heart condition?

_____

CONDITION 1

- Describe your symptoms. _____

_____

_____

- When did your symptoms start? _____ How does it feel? (ache, sharp, burn, etc.) _____
- What caused them? _____
- What makes you feel worse? _____
- What makes you feel better? _____
- Does the pain travel or spread? _____ If so, where? _____ Do you have any numbness? _____
- How much of the day do you experience symptoms? 0-25% 26-50% 51-75% 76-100% _____
- Have you had similar problems in the past? _____
- Have you seen any other physicians for this condition? _____
- What activities do you do that are currently difficult, that you would like to perform better?

_____

- Is there anything else you would like to mention or discuss?

_____

CONDITION 2

- Describe your symptoms. _____

_____

_____

- When did your symptoms start? _____ How does it feel? (ache, sharp, burn, etc.) _____
- What caused them? _____
- What makes you feel worse? _____
- What makes you feel better? _____
- Does the pain travel or spread? _____ If so, where? _____ Do you have any numbness? _____
- How much of the day do you experience symptoms? 0-25% 26-50% 51-75% 76-100% _____
- Have you had similar problems in the past? _____
- Have you seen any other physicians for this condition? _____
- What activities do you do that are currently difficult, that you would like to perform better?

_____

- Is there anything else you would like to mention or discuss?

_____

Auto Accident Information

Patient Name _____ Date of Birth _____ File # _____
office use only

Accident Details

Date of Accident: _____ Time of Accident: _____

Location/Street/Intersection: _____ Number of Vehicles Involved: _____

Was there a Police Report filed? ☐ No ☐ Yes : *if so please provide case number* _____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger *Name of driver:* _____

Model of *your* vehicle: _____ Model of *other* vehicle: _____

Were you wearing a seatbelt? ☐ Yes ☐ No Did airbags deploy? ☐ Yes ☐ No

How much damage was there to your vehicle? ☐ Minor/Aesthetic ☐ Significant but drivable ☐ Totaled

Where did the impact come from? ☐ Front ☐ Rear ☐ Driver Side ☐ Passenger Side

During the impact were you facing: ☐ Forward ☐ Backward ☐ Looking to the right ☐ Looking to the left

Did any part of your body strike anything in the vehicle? ☐ No ☐ Yes *(please describe):* _____

_____

Were you rendered unconscious? ☐ No ☐ Yes *if so, for how long?* _____

What was the approx. speed of your vehicle? _____ The other vehicle? _____

Were you ☐ aware/bracing for impact ☐ caught off guard/not prepared

After the Accident

Did you experience symptoms… ☐ Immediately after accident ☐ Hours afterward ☐ Days afterward

Did you receive any medical care at the scene of the accident? ☐ No ☐ Yes

Did you receive care from the hospital or urgent care afterwards? ☐ No ☐ Yes

Have you seen any other healthcare providers for pain/injuries since the accident? ☐ No ☐ Yes

If YES to any of the above…

Who was the healthcare provider? _____

Did they do any imaging such as X-Ray, MRI, CT, etc? ☐ Yes ☐ No

What treatments or medications did you receive? _____

Did they recommend any follow-up care? _____

Your Auto Insurance

Name of Insurance Co: _____ Claim # _____

Name of Adjuster: _____ Adjuster's Phone: _____

Liability Carrier (Driver at Fault)

Name of Insurance Co: _____ Claim # _____

Name of Adjuster: _____ Adjuster's Phone: _____

Have you retained an attorney? ☐ Yes ☐ No

If yes, please provide name and contact info: _____

Chiropractic Partners
RESTORING HEALTH AND WELLNESS

Patient Name: _____ File #: _____ Date: _____

ARE YOU *CURRENTLY EXPERIENCING* OR HAVE YOU HAD A *SIGNIFICANT HISTORY* WITH ANY OF THE FOLLOWING SYMPTOMS? PLEASE INDICATE BELOW.

General, Constitutional		**Musculoskeletal**	
Good general health lately	no yes	Muscle pain or cramps	no yes
Recent weight change	no yes	Joint swelling	no yes
Fever	no yes	Weakness of muscles/joints	no yes
Fatigue	no yes	Cold hands or feet	no yes
Out of shape/Overweight	no yes	One leg shorter than the other	no yes
Cancer	no yes	Difficulty in walking	no yes
Eyes and Vision		Foot/Ankle/Knee/Hip pain	no yes
Eye disease or injury	no yes	Orthotics	no yes
Wear glasses or contact lenses	no yes	**Skin and Breasts**	
Blurred or double vision	no yes	Rash or itching	no yes
Ears, Nose, and Throat		Change in skin color	no yes
Hearing loss	no yes	Breast lump	no yes
Ringing in the ears	no yes	Breast pain	no yes
Earaches or drainage	no yes	Breast discharge	no yes
Sinus problems	no yes	**Neurological**	
Swollen glands in neck	no yes	Paralysis	no yes
Nose bleeds	no yes	Frequent/recurrent headache	no yes
Bleeding gums	no yes	Light headed or dizzy	no yes
Sore throat or voice change	no yes	Head injury	no yes
Heart, Cardiovascular		Stroke	no yes
Pacemaker	no yes	Tremors	no yes
Swelling of feet, ankles, hands	no yes	Numbness or tingling	no yes
Heart trouble	no yes	Convulsions or seizures	no yes
Chest pains	no yes	**Endocrine**	
Sudden heartbeat changes	no yes	Dry skin	no yes
Respiratory		Heat/cold intolerance	no yes
Spitting up blood	no yes	Glandular/hormone problem	no yes
Frequent coughing	no yes	Change in hat/glove size	no yes
Painful bowel movements	no yes	Thyroid disease	no yes
Blood in stool	no yes	Diabetes	no yes
Loss of appetite	no yes	Excessive thirst/urination	no yes
Loss of bowel/bladder control	no yes	**Hematologic/Lymphatic**	
Stomach pain	no yes	Anemia	no yes
Nausea or vomiting	no yes	Transfusions	no yes
Genitourinary		Swollen glands	no yes
Burning or painful urination	no yes	**Psychiatric**	
Irregular periods	no yes	Memory loss or confusion	no yes
Kidney stones	no yes	Sleep problems	no yes
Frequent urination	no yes	Depression	no yes
Incontinence or dribbling	no yes	Anxiety	no yes
Blood in urine	no yes		

Patient Signature _____

I have read and reviewed the above information with the patient. _____

Informed Consent for Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below 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 below, including those working at other Chiropractic Partners offices.

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. I consent to rely on the doctor's best judgment, exercised during the course of treatment that is in my best interest, based upon the known facts.

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 conditions(s) and for any future condition(s) for which I seek treatment.

To be completed by patient:

_____ _____

Print Patient Name Date Signed

_____

Patient Signature

To be completed by Patient's representatives, if necessary, e.g. if patient is a minor or is physically or mentally incapacitated:

_____ _____

Print Patient Name Date Signed

_____

Signature of Patient's Representative

Chiropractic Partners
RESTORING HEALTH AND WELLNESS

Daniel Keadle DC, Brian Ransone DC
7116–A Six Forks Rd, Raleigh, NC 27615
T: 919-847-3122 | F: 919-847-3148

Chiropractic Partners
Brian Ransone DC, Daniel Keadle DC
7116 Six Forks Rd.
Raleigh, NC 27615
(919) 847-3122

Authorization for Disclosure of Health Information and Direct Contact

Our Privacy Pledge

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

Disclosures of protected health information

Listed below are several reasons for having to use or disclose your PHI (personal health information)

- We may have to disclose your information to another healthcare provider or hospital should we refer you to them for a diagnosis, assessment, or treatment of your health condition.
- We may have to disclose PHI and /or billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your PHI within our practice for quality control or operational purposes.

Your right to limit uses of disclosure

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your PHI, we will respectfully request that you submit these restrictions in writing. With your right to restriction, you also have the right to revoke your authorization or consent to us at any time. Again, this change of authorization is requested in writing before your file status will be changed.

ESTABLISHED PATIENTS: We have a more complete notice that provides a detailed description of how your information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520) and is available upon your request. Please sign below to confirm this for has been gone over with you. **NEW PATIENTS:** In your packet of new patient information you will find our Notification of Patient Privacy Policy. Please sign below to confirm that you have received it.

Authorization and permission

In general, the HIPAA privacy rule gives individuals the right to request a restriction on used and disclosures of their PHI. The individual is also provided the right to request confidential communications, such as reminders of appointment times, follow up of health care, insurance coverage's/benefits issues or any other information that only the patient will personally be able to answer.

Below, please authorize any person(s) that we may discuss your treatment/finances with or that we may release your medical records to. Those listed below will also have your permission to schedule or change appointments on your behalf as needed.

Person 1:_____

Person 2:_____

I give Chiropractic Partners permission to leave appointment reminders at the flowing location: (circle primary)

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

I give permission for you to contact me regarding my personal health information by email. I understand that email is not a confidential method of communication and may be unsecure. I also understand that I may opt out at any time by notifying your office.

Email:_____

Patient Signature_____**Date**_____

Print Name_____**Date of Birth**_____**Chart #**_____

Patient Protection Care Act Information

General Information

First Name _____ Date_____
Middle Initial _____ Acct#_____
Last Name _____ DOB _____

Race (please only circle one): American Indian Alaska Native
Asian Caucasian
African American Other Pacific Islander
Native Hawaiian Decline to State

Ethnicity (please only circle one): Decline to State Hispanic or Latino Not Hispanic or Latino

Preferred Language: _____

Email Address: _____

Height: _____ Weight: _____

Do you have any history in your **immediate family** of health disease?
(I.e. cancer, high blood pressure, diabetes, high cholesterol, or heart disease)
If yes, please indicate **who and the health disease**:_____
_____

Smoking Status (please only circle one): Current Every Day Smoker
Current Some Day Smoker
Former Smoker
Never Smoked
Decline to State
In an effort to quit smoking, I am currently taking:_____

Do you have any allergies to medication? Yes No
If yes, please indicate: _____
_____

Are you currently taking any medication: Yes No
If yes, please indicate: _____
_____
_____
_____

----------*Office Use Only*----------

*Blood Pressure:*_____ *Pulse:*_____