

CEL PH# _____

Patient Name _____ Birthdate _____ Sex: M / F
Address _____ City _____
State _____ Zip _____ Phone (____) _____ Patient Primary Language _____
Occupation _____ Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Subscriber Name _____ Health Plan _____
Subscriber ID# _____ Group # _____ Spouse Name _____
Spouse Employer _____ City _____ State _____ Zip _____
Primary Care Physician Name _____ PCP Phone _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

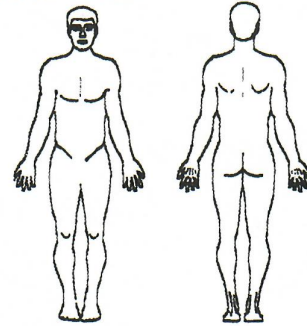
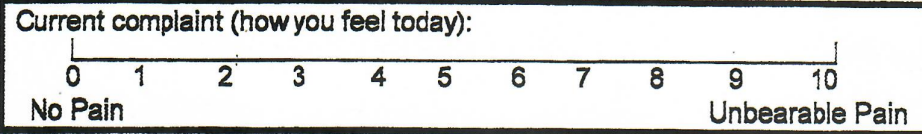
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

- Headache Neck Pain Mid-Back Pain Low Back Pain
 Other _____

Is this? Work Related Auto Related N/A

Date Problem Began _____

How Problem Began _____



How often are your symptoms present?

- (Occasional) 0 - 25% 26 - 50% 51 - 75% 76 - 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:

- Excellent Very Good Good Fair Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? No Yes

Date(s) taken _____ What areas were taken? _____

Please check all of the following that apply to you:

- Alcohol/Drug Dependence
- Recent Fever
- Diabetes
- High Blood Pressure
- Stroke (Date) _____
- Corticosteroid Use (Cortisone, Prednisone, etc.)
- Taking Birth Control Pills
- Dizziness/Fainting
- Numbness in Groin/Buttocks
- Cancer/Tumor (Explain) _____
- Osteoporosis
- Epilepsy/Seizures
- Other Health Problems (Explain) _____

- Allergies _____
- Prostate Problems
- Menstrual Problems
- Urinary Problems
- Currently Pregnant, # Weeks _____
- Abnormal Weight Gain Loss
- Marked Morning Pain/Stiffness
- Pain Unrelieved by Position or Rest
- Pain at Night
- Visual Disturbances
- Surgeries _____
- Tobacco Use - Type _____
- Frequency _____/Day
- Medications _____

Family History: Cancer Diabetes High Blood Pressure
 Heart Problems/Stroke Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature _____ Date _____

**ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

If there is an instance where someone would need to pick up x-rays, records, etc., or speak to the Doctor on your behalf, their name **MUST** appear on this form. The individuals listed will need to present photo ID.

I give my consent to the following persons to discuss my medical condition with Doctor Nathan A. Carter and /or staff at Carter Chiropractic & Wellness Center.

_____ Relationship _____
_____ Relationship _____
_____ Relationship _____

IN CASE OF EMERGENCY CONTACT: _____ PH# _____

_____ Patient Name (print) _____ Date _____

_____ Parent, Guardian or Patient's legal representative

_____ Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

**CARTER CHIROPRACTIC & WELLNESS CENTER
608 DECATURE AVE. BROOKSVILLE, FL 34601 352-796-7201**