First Name ________________ **Middle Initial** ____ **Last Name** ______________________

Address Line 1 ____

Address Line 2 ____

City ___________________________ **State** ________________ **Zip Code** ____________

Home Phone (____) _______-__________ **Work Phone** (____) ________-___________

Cell Phone (____) _______-___________ **Email** ______________________________

Date of Birth _____/_____/______ **May we contact you by text and email?**_______

Gender you were born as: ☐ Male ☐Female

Gender- How do you idendify? ☐Man ☐Non binary ☐Woman ☐Transgender
☐Prefer self described as:_____________☐Prefer not to answer

Employment Status: ☐ Employed☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other__

Occupation:________________

Emergency Contact:

Contact Name _________________________ **Relationship to Patient**________________

Contact Home Phone (____) _____-________**Cell Phone** (___) ______-__________

Payment/Insurance Information:

Who is responsible for your bill? ☐ **Self** ☐ **Health insurance** ☐ **Spouse** ☐ **Worker's Comp**
☐**Auto Ins.** ☐ **Other** ___________________________

Insurance Company Name: ____

Ins. Card ID# _______________________ **Group #** _________________

Personal injury/MVA Insurance Claim # __________________________

Adjuster Name and phone:____

Primary Physician Name and Number: ____________________________________

May we communicate with your PCP regarding your care? Y/N

Date of last exam: ____________

Name of most recent Chiropractor: ____________________ **Date of last visit**____________

How did you hear about our office? ____

Medical Conditions: (Check all that apply to you)

☐ Arthritis ☐ Cancer ☐ Diabetes ☐Heart Disease
☐ Hypertension ☐ Psychiatric Illness ☐ Skin Disorder ☐Stroke
☐ Other ______________

Surgeries: (Check all that apply to you)

☐ Appendectomy ☐ Cardiovascular procedure ☐ Cervical spine ☐ Hysterectomy
☐ Joint Replacement ☐ Prostate ☐ Lumbar spine ☐ Gall Bladder
☐ Brain ☐ Shoulder ☐ Thoracic spine ☐ Knee
☐ Carpal Tunnel ☐ Gastro-intestinal ☐ Uro-genital ☐ Hernia
☐ Other ______________

Fractures: ____________________ Date of injury:________
____________________ Date of injury:________
____________________ Date of injury:________

Social History: (Check all that apply to you)

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Chew Tobacco:	☐ occasional	☐ often	☐ never
Cigarettes:	☐<1 pack/day	☐ >1 pack/day	☐ never
Wear Seat Belts:	☐ occasional	☐ always	☐ never

Other ________________

Family History: (Check all that apply)

Arthritis:	☐ Parent	☐ Sibling
Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling
Heart Disease	☐ Parent	☐ Sibling
Hypertension	☐ Parent	☐ Sibling
Stroke	☐ Parent	☐ Sibling
Thyroid	☐ Parent	☐ Sibling

Other ________________

Occupational Activities: (Check one that best describes your job description)

☐ Administration ☐ Business Owner ☐ Clerical/Secretary ☐ Computer User
☐ Heavy Equipment operator ☐ Daycare/Childcare ☐ Construction ☐ Health Care
☐ Food Service Industry ☐ Medium Manual Labor ☐ Manufacturing ☐ Home Services
☐ Heavy Manual Labor ☐ Light Manual Labor ☐ Executive/Legal ☐ Housekeeper
☐ Other ________________

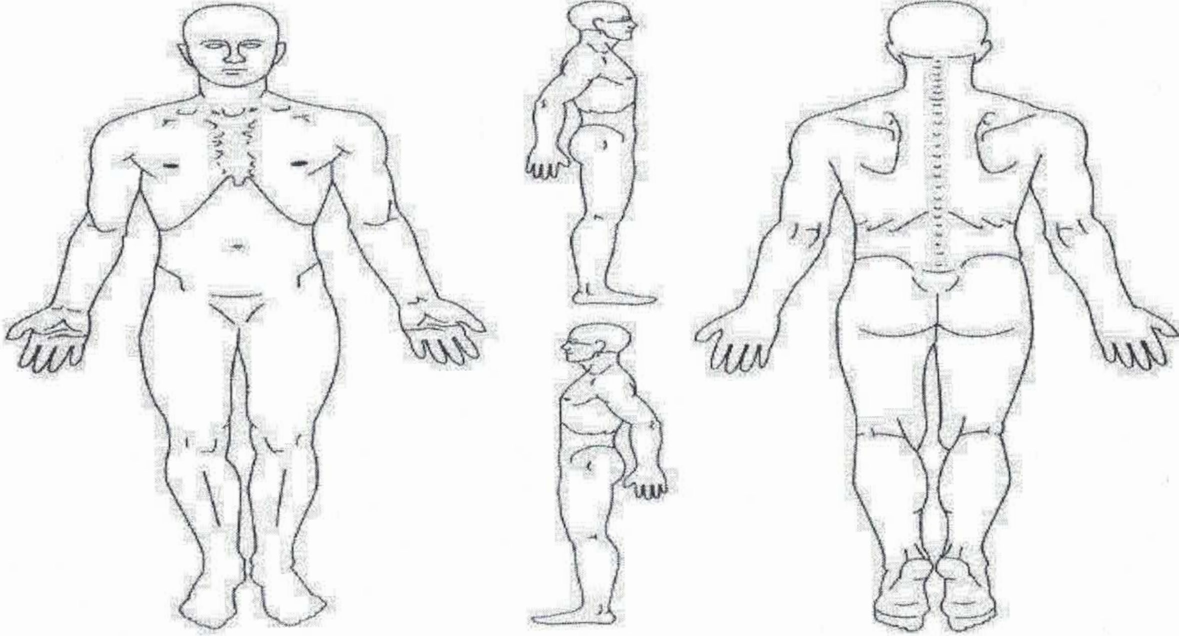
Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Are you pregnant? Yes_____ No ______N/A______

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: ____________________

____

____

____

When did your symptoms begin? Month____________Day__________Year______________

What are your goals for chiropractic care?______________________________________

Previous interventions, treatments, surgeries or care you have sought for your complaint______

____

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐Work related Accident ☐ Other_____

How did your symptoms begin? ____

____

How often do you experience your symptoms?

☐ Constantly	☐ Frequently	☐ Occasionally	☐ Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What describes the nature of your symptoms?

□Sharp □Dull Ache □Numb □Shooting □Burning □Tingling □Stabbing □ Other_______

How are your symptoms changing?

□Same □Not Changing □Getting Worse

Describe your secondary complaint:____

When did your symptoms begin? Month____________Day_______________Year ____________

Did it begin □Gradual □Sudden □Progessive over time

How often do you experience these symptoms?

□ 25% □ 50% □ 75% □ 100%

Does the pain radiate into your:

□ Arm □ Leg □Does not radiate

Do you have numbness or tingling? Y/N

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no pain. 10 being extreme)__________

What makes your symptoms increase/worse (Activities)_____________________________

____

What makes your symptoms decrease/better?_____________________________________

____

Have you had similar symptoms in the past? Y/N If so, when?___________________________

Are your symptoms worse at certain times of the day? Y/N If so, when?____________________

Medications/supplements: ____

Exercise//Hobbies: ____

Automobile Accident Questionnaire

Patient Name: ______________________ Date of birth: ______________

Address: ______________________ Email: ______________

______________________ Phone: ______________

Accident Information

1. Date of Accident: ______________________ Time: ______________ AM/PM

2. Driver of Car: ______________________ Patient Seated: ______________

3. Owner of Car: ______________________ Year and Model of Car: ______________

4. Visibility (at time of accident) POOR/FAIR/GOOD/OTHER: ______________

5. Road Conditions (at time of accident) ICY/RAINY/WET/CLEAR/DARK/OTHER: ______________

6. Where was your car struck? RIGHT/LEFT/REAR/FRONT/SIDE/OTHER: ______________

7. Type of Accident: ☐ Head-On Collision ☐ Broad-Side Collision (T-Bone) ☐ Rear-End Collision

☐ Front Impact, Rear-Ended Car In Front ☐ Non-Collision: ______________

8. What part of the car was damaged? ______________

9. Describe what happened to you upon impact? ______________

10. Did you see the accident was about to happen? ☐ YES ☐ NO

11. Did you brace for impact? ☐ YES ☐ NO

12. Were you wearing a seatbelt? ☐ YES ☐ NO

13. Were you wearing a shoulder harness? ☐ YES ☐ NO

14. Does the car have headrests? ☐ YES ☐ NO

If yes, what was the position of your headrest?

☐ top of headrest even with bottom of head

☐ top of headrest even with top of head

☐ top of headrest even with middle of head

15. Was your car braking? ☐ YES ☐ NO Was the other car braking? ☐ YES ☐ NO

16. Was your car moving at the time of the accident? ☐ YES ☐ NO

If yes, how fast would you estimate you were going? ______________ MPH

17. How fast would you estimate the other car was traveling? ______________ MPH

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OAK CITY CHIROPRACTIC

18. What was the position of your head and body at the time of impact?

☐ head turned left/right ☐ body straight in sitting position ☐ head looking back
☐ body rotated left/right ☐ head straight forward ☐ other:______________________________

19. At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:

____

____

20. As a result of the accident were you: ☐ RENDERED UNCONSCIOUS ☐ DAZED ☐ OTHER____________________

21. Could you move all parts of your body? ☐ YES ☐ NO

If no, why not? ____

22. Were you able to get out of the car and walk unaided? ☐ YES ☐ NO

If no, why not? ____

23. Did you have any cuts or bruises from this accident? ☐ YES ☐ NO

If so, where? ____

24. Describe how you felt immediately after the accident: _________________________________

____

How did you feel later that ☐ DAY ☐ NIGHT ____

____

How did you feel the next day(s)? ____

____

25. Check symptoms apparent <u>since</u> the accident:

☐ headache	☐ loss of smell	☐ numbness in fingers	neck pain/stiffness
☐ loss of taste	☐ cold hands	☐ mid-back pain	☐ loss of memory
☐ cold feet	☐ low-back pain	☐ fatigue	☐ diarrhea
☐ tension	☐ constipation	☐ pain behind eyes	☐ chest pain
☐ irritability	☐ dizziness	☐ shortness of breath	☐ nervousness
☐ fainting	☐ depression	☐ cold sweats	☐ anxious
☐ sleeping problems	☐ loss of balance	☐ numbness in toes / fingers	☐ other:______
☐ ringing/buzzing in ears		☐ eyes sensitive to light	

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26. Have you missed time from work? ☐ YES ☐ NO Type of Employment: ☐ FULL-TIME ☐ PART-TIME

If yes, how much time have you missed? ____________________

What was your first date of missed work? ____________________

27. Did the accident occur during your work hours? ☐ YES ☐ NO

28. Did you seek medical help immediately/soon after the accident? ☐ YES ☐ NO

If yes, how did you get there? ____________________

29. Doctor/Hospital/Clinic seen at: ____________________ Date: ____________

What was done? ____________________

Were x-rays taken? ☐ YES ☐ NO If yes, of what body part? ____________________

30. What treatments/prescriptions were given? Bed Rest Brace Adjustments Medications

31. What benefit(s) did you receive from these treatment(s)? ____________________

____

32. Date of last treatment: ____________________

33. Are any of your activities of daily living any different now compared to before the accident? ☐ YES ☐ NO

List anything you are UNABLE to do: ____________________

List anything that is PAINFUL to do: ____________________

List anything that is DIFFICULT to do: ____________________

34. Do you have an attorney handling this case? ☐ YES ☐ NO

If yes, who? (NAME/PHONE/FIRM)____________________

____

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Insurance Information

Name of Individual Insured (if other than patient) ____________________

Policy #: ____________________

Claim #: ____________________

Insurance Company Name: ____________________

Phone#: ____________________

Address: ____________________ City: ____________________ State/Zip: ____________________

Adjuster's Name: ____________________ Phone: ____________________

Other Party's Insurance: ____________________

Name of Individual Insured (if other than patient) ____________________ Policy #: ____________________

Insurance Company Name: ____________________ Phone#: ____________________

Address: ____________________ City: ____________________ State/Zip: ____________________

Claim #: ____________________

Adjuster's Name: ____________________ Phone#: ____________________

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Dr. Jessica Fay, DC
Dr. Cheyne Ashline, D.C.
Oak City Chiropractic, PLLC
875 Washington St
Raleigh, NC 27605
Phone: (919) 213-0881
Fax: (919) 346-7933

IRREVOCABLE ASSIGNMENT, LIEN AND AUTHORIZATION INSURANCE BENEFITS AND ATTORNEY

To Whom It May Concern:

I hereby authorize and direct you, **my Insurance carrier and/or Attorney, to pay directly to Oak City Chiropractic PLLC** sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident, worker's compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect said office. This is to act as an assignment of my rights and benefits to the office's services provided.

In the event my insurance carrier obligated to make payment to me upon the charges made by this office for their services refuses to make such payment upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that might exist in my favor against such carrier and authorize this office to prosecute said cause of action either in my name or in the offices name, and further, I authorize this office to compromise, settle, or otherwise resolve such claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this assignment, lien and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance carrier, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization.

I further understand and agree that if this office must take any action to collect an outstanding balance on this account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including but not limited to all court and attorney fees.

I hereby authorize my Attorney to pay the outstanding balance at settlement under NC General Statute 44-49 and 50.

Printed Name: ________________________________

Signature: ____________________________________

Date: ______________

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic X-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

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 procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: ______________________________

Signature of Patient: ______________________________

Name Printed of Guardian/Parent and Relationship to Patient: ______________________________

Signature of Guardian/Parent: ______________________________

Date: ______________

Doctor of Chiropractic Name: ______________________________

Signature of Doctor of Chiropractic: ______________________________

Date: ______________

Oak City Chiropractic

Cancellation Policy

As part of our continued effort to provide you with the best care and accommodate all appointment requests, we have implemented a 24 hour cancellation policy with a $45 missed appointment fee.

If you cannot make your scheduled appointment, please call us at **919-213-0881** and cancel at least 24 hours prior to your appointment so that Dr. Fay may accommodate other patients. To cancel or make changes to Monday appointments please call over the weekend and leave a voice message.

We appreciate your timeliness should you need to rearrange or reschedule your appointments. Of course, we are courteous with emergencies.

I have read and understand this policy:

Patient Name (Print) ____________________________

Patient Signature (or Parent/Legal Guardian) ____________________________

Date _____________

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You make revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient or Representative: ______________________________

Printed Name: ______________________________

Date: ______________