

# REGISTRATION

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: M  F   
 Single  Married  Widowed  Separated  Divorced  Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Email: \_\_\_\_\_  
 Insured's Name: \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance coverage with \_\_\_\_\_ and assign directly to **Asheville Spine & Injury Center** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Present Complaints (Please circle the appropriate ones)</b>												
Headache	Feet/Hands Cold	Unbalanced										
Mental dullness	Depression	Fainting										
Loss of memory	Rib pain	Blurred vision										
Dizzy	Nervousness	Irritability										
Ears ringing/buzzing	Eye strain/pain	Double vision										
Upper back pain	Shortness of breath	Loss of smell										
Lower back pain	Fear	Chest pain										
Midback pain	Confusion	Neck pain										
Pins and needles in hands	Pins and needles in arms	Pins and needles in legs										
right/left	right/left	right/left										
<b>Medical Implants:</b> _____				<b>Medical alerts:</b> _____								
<b>Surgical Implants:</b> _____				<b>Pregnancy:</b> yes ___ no ___								
<b>PAIN SCALE:</b> Rate the severity of your pain by checking a box on the following scale.												
<b>No Pain</b>	0	1	2	3	4	5	6	7	8	9	10	<b>Excruciating Pain</b>

**Medications:** (please list all medications and supplements that you currently take, or provide list to staff for copy)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergies:** (please list all medications that cause allergic reaction)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Surgical History:** Please list ALL previous surgery and the date on which it was performed:

Surgery _____	Date _____
_____	_____
_____	_____

**Smoking:** \_\_\_ Yes \_\_\_ No If yes, \_\_\_\_\_ Packs per Day for \_\_\_\_\_ years

**Alcohol** \_\_\_ Yes \_\_\_ No If yes, Number of drinks per week \_\_\_\_\_

**Personal Medical History & Review of Systems:**

**NO MEDICAL PROBLEMS** - no prior history of any significant medical problems  
 Please indicate with an "X" any medical problems that you currently have or have had in the past.

**Lungs / Pulmonary – breathing disorders**

- |   |                                      |                                       |
|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> asthma             | <input type="checkbox"/> COPD        | <input type="checkbox"/> emphysema    |
| <input type="checkbox"/> pulmonary embolism | <input type="checkbox"/> pneumonia   | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> respiratory arrest | <input type="checkbox"/> sleep apnea | <input type="checkbox"/> other: _____ |

**Cardiac / Heart and peripheral vascular disease**

- chest pain / angina
- irregular heartbeat, arrhythmia
- heart attack, myocardial infarction
- heart murmur, valve disorder
- peripheral vascular disease
- congestive heart failure
- mitral valve prolapse
- deep vein thrombosis
- bleeding problems
- high blood pressure
- Other \_\_\_\_\_

**Neurologic Disorders**

- stroke or TIA
- Parkinson's
- cerebral palsy
- peripheral neuropathy
- MS
- polio
- other: \_\_\_\_\_

**Bone & Joint Disorders**

- osteoarthritis
- rheumatoid arthritis
- ankylosing spondylitis
- osteomyelitis
- gout
- lupus
- other: \_\_\_\_\_

**Gastrointestinal Disorders**

- peptic ulcer or stomach ulcer
- diverticulitis
- hepatitis - Type \_\_\_\_\_
- acid reflux, GERD
- irritable bowel
- liver disease
- GI bleed
- inflammatory bowel disease
- other: \_\_\_\_\_

**Genitourinary Disorders**

- urinary tract infection
- kidney problems
- kidney stones
- dialysis, kidney failure
- bladder problems
- other: \_\_\_\_\_

**Metabolic & Other Disorders**

- tooth abscess, gingivitis
- Diabetes x \_\_\_\_\_ years
- skin disorder \_\_\_\_\_
- depression
- anxiety
- thyroid problems
- psoriasis
- skin ulcer
- sickle cell disease
- alcohol or drug dependency
- high cholesterol or lipids
- other: \_\_\_\_\_

Cancer : any type -- please specify \_\_\_\_\_

Other medical problems NOT included above (explain) \_\_\_\_\_

**Family History:** Please indicate with an "X" any significant family medical history or problems

- asthma
- sleep apnea
- COPD
- Emphysema
- tuberculosis
- other lung: \_\_\_\_\_
- heart attack, myocardial infarction
- congestive heart failure
- irregular heartbeat, arrhythmia
- bleeding problems
- other heart : \_\_\_\_\_
- Peripheral neuropathy
- sickle cell disease
- MS or Parkinson's
- other neuro : \_\_\_\_\_
- osteoarthritis
- Lupus
- gout
- rheumatoid arthritis
- Other bone & joint: \_\_\_\_\_
- acid reflux, GERD
- hepatitis - Type \_\_\_\_\_
- inflammatory bowel disease
- liver disease
- Malignant hyperthermia
- other GI : \_\_\_\_\_
- kidney problems
- dialysis
- diabetes
- psoriasis
- skin ulcer
- high cholesterol or lipids
- thyroid problems
- Cancer : type -- please specify

Other medical problems NOT included above (explain) \_\_\_\_\_

**PATIENT INSURANCE INFORMATION:** check any and all insurance coverage you or your spouse have in this case

- Major Medical
- Workman's Compensation
- Auto Injury Insurance
- Blue Cross Blue Shield
- Medicare
- Other

Insurance Identification #: \_\_\_\_\_ Medicare ID #: \_\_\_\_\_

Major Medical or Auto Insurance Company Name: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Adjuster: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Claim #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Primary Care Physician: Name & Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

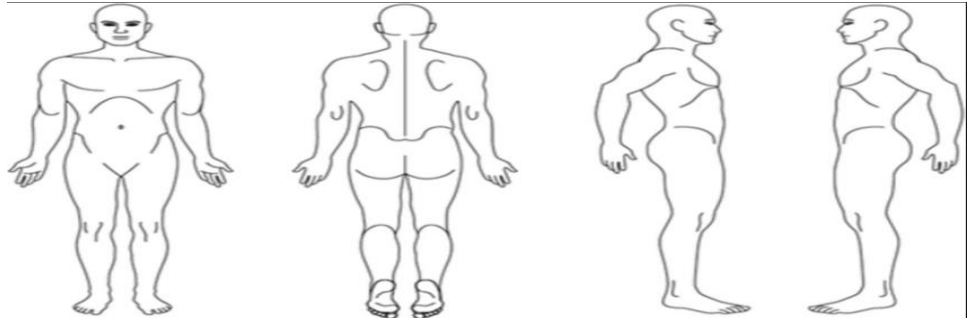
LEGAL INFORMATION: Attorney Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

\*Person to contact in an emergency Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please indicate on the drawings to the right where you have pain/symptoms.



List your health concerns from *greatest to the least* starting from **Column #1**

	Most Pressing issue	2 <sup>nd</sup> Most important	3 <sup>rd</sup> Most important	4 <sup>th</sup> Most important
<b>Current Complaints</b> List worst to minor complaints	<b>1<sup>st</sup></b> _____ Left Right Both	<b>2<sup>nd</sup></b> _____ Left Right Both	<b>3<sup>rd</sup></b> _____ Left Right Both	<b>4<sup>th</sup></b> _____ Left Right Both
Rate this problem on scale 0-----10 0=No pain 10=Excruciating	0 1 2 3 4 5 6 7 8 9 10 0=No pain 10=Excruciating	0 1 2 3 4 5 6 7 8 9 10 0=No pain 10=Excruciating	0 1 2 3 4 5 6 7 8 9 10 0=No pain 10=Excruciating	0 1 2 3 4 5 6 7 8 9 10 0=No pain 10=Excruciating
How often do you feel this complaint?	Constant Frequently Intermittent Occasional	Constant Frequently Intermittent Occasional	Constant Frequently Intermittent Occasional	Constant Frequently Intermittent Occasional
Circle <b>all</b> that apply that describes the quality of your complaint.	Dull Achy Numb Tingling Stiff Burning Sharp Throbbing Shooting Radiating Other: _____	Dull Achy Numb Tingling Stiff Burning Sharp Throbbing Shooting Radiating Other: _____	Dull Achy Numb Tingling Stiff Burning Sharp Throbbing Shooting Radiating Other: _____	Dull Achy Numb Tingling Stiff Burning Sharp Throbbing Shooting Radiating Other: _____
Is this getting?	Better Worse Same	Better Worse Same	Better Worse Same	Better Worse Same
If this pain travels or spreads, what area(s) are affected?	_____	_____	_____	_____
How long has this been a problem?	_____	_____	_____	_____
What makes your pain worse?	_____	_____	_____	_____
What gives you some relief?	_____	_____	_____	_____
What have you done to take care of this complaint?	MD, PT, Massage Ice/heat Stretch Rest Exercise Medications Other: _____	MD, PT, Massage Ice/heat Stretch Rest Exercise Medications Other: _____	MD, PT, Massage Ice/heat Stretch Rest Exercise Medications Other: _____	MD, PT, Massage Ice/heat Stretch Rest Exercise Medications Other: _____
Did it work?	Yes Partially No Slightly	Yes Partially No Slightly	Yes Partially No Slightly	Yes Partially No Slightly
This is affecting my Life in the following areas:	Work Cooking Sleep Cleaning Self-Care Dishes Yard Work Gardening Hobbies Home Maintenance	Work Cooking Sleep Cleaning Self-Care Dishes Yard Work Gardening Hobbies Home Maintenance	Work Cooking Sleep Cleaning Self-Care Dishes Yard Work Gardening Hobbies Home Maintenance	Work Cooking Sleep Cleaning Self-Care Dishes Yard Work Gardening Hobbies Home Maintenance

Notes: \_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed: \_\_\_\_\_

## PAIN DISABILITY QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?  
Work normally Unable to work at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
2. Does your pain interfere with personal care (such as washing, dressing, etc.)?  
Take care of myself completely Need help with all my personal care  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
3. Does your pain interfere with your traveling?  
Travel anywhere I like Only travel to see doctors  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
4. Does your pain affect your ability to sit or stand?  
No problems Can not sit/stand at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?  
No problems Can not do at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?  
No problems Can not do at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
7. Does your pain affect your ability to walk or run?  
No problems Can not walk/run at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
8. Has your income declined since your pain began?  
No decline Lost all income  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
9. Do you have to take pain medication every day to control your pain?  
No medication needed On pain medication throughout the day  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
10. Does your pain force you to see doctors much more often than before your pain began?  
Never see doctors See doctors weekly  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?  
No problem Never see them  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
12. Does your pain interfere with recreational activities and hobbies that are important to you?  
No interference Total interference  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?  
Never need help Need help all the time  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
14. Do you now feel more depressed, tense, or anxious than before your pain began?  
No depression/tension Severe depression/tension  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?  
No problems Severe problems  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

\_\_\_\_\_  
Examiner

**OTHER COMMENTS:**

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With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.

# INFORMED CONSENT FORM

Please read this entire document prior to signing it. It is very important that you understand the information contained in this document. If anything is unclear, please ask questions.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. I am required to advise patients that there are risks associated with such treatment. In particular you should note.

1. Some patients will feel some stiffness and soreness following the first few days of treatment.
2. Some types of manipulation have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The incidences are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments.
3. Other complications may include: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.
4. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probabilities of those risks are rare and generally result from some underlying weakness of the bone which I check for while taking your history and during examination and/or X-rays.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

Discuss these with your primary medical provider for the risks and benefits of using these options.

The risks and dangers of not treating may lead to the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with Dr. Stockstad. I have had my questions answered to my satisfaction and consent to care for all my present and future chiropractic care.

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Witness Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent or Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Asheville Chiropractic**  
16 Winterwind Drive  
Asheville, NC 28803  
(828)-299-4555

**Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)**

In this document, “I” and “my” refer to the patient and “Chiropractor” refers to Vibrant Health Source of Asheville, North Carolina.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of chiropractor. I understand that analysis, diagnosis or treatment of me by chiropractor may be conditioned upon my consent as evidenced by my signature below. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry our treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has already released your health information before we received your request to revoke your authorization.

My “protected health information” includes my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information identifies me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information with respect to my treatment, payment of my bills or in the performance of health care operation of chiropractor. The Notice of Privacy practices for Chiropractor is also posted in the waiting room at 16 Winterwind Drive. This Notice of Privacy Practices also describes my rights and the duties of the Chiropractor with respect to my protected health information. Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

**Appointment Reminder Notification and Healthcare Information (5/03)** We may need to contact you by mail, e-mail, or phone to provide you with appointment reminders, treatment alternatives, and other health related information that may be of interest and importance to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine.

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Print name of personal representative

\_\_\_\_\_  
Description of personal representative authority to act for the patient