

REGISTRATION

Name: _____ Age: _____ Birthdate: _____ Sex: M F
 Single Married Widowed Separated Divorced Occupation: _____
 Address: _____ City _____ State _____ Zip _____
 Phone: _____ Email: _____
 Social Security #: _____
 Person to contact in an emergency Name: _____ Phone #: _____
 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: _____

Present Complaints (Please circle the appropriate ones)

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

Medical Implants: _____ Medical alerts: _____
 Surgical Implants: _____ Pregnancy: yes ___ no ___

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Excruciating Pain

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 #: _____

Signature: _____ **Date:** _____

Name: _____

Date: _____

Medications: *(Please list all medication 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 (approximately) it was performed:

Surgery _____	Date _____
Surgery _____	Date _____
Surgery _____	Date _____
Surgery _____	Date _____
Surgery _____	Date _____
Surgery _____	Date _____


Patient Signature: _____

Reviewed _____

Patient's Name: _____

Date: _____

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

	Most Pressing issue	2 nd Most important	3 rd Most important	4 th Most important
Current Complaints List worst to least	1 st _____ _____ Left Right Both	2 nd _____ _____ Left Right Both	3 rd _____ _____ Left Right Both	4 th _____ _____ Left Right Both
How often do you feel this complaint?	Constant Frequently Intermittent Occasional	Constant Frequently Intermittent Occasional	Constant Frequently Intermittent Occasional	Constant Frequently Intermittent Occasional
When did this pain or restriction start?	___ Days ___ Weeks ___ Months ___ Years	___ Days ___ Weeks ___ Months ___ Years	___ Days ___ Weeks ___ Months ___ Years	___ Days ___ Weeks ___ Months ___ Years
Circle all that describes the quality of your complaint.	Dull Sharp Tingling Achy Burning Numb Stabbing Throbbing Restricted Stiff	Dull Sharp Tingling Achy Burning Numb Stabbing Throbbing Restricted Stiff	Dull Sharp Tingling Achy Burning Numb Stabbing Throbbing Restricted Stiff	Dull Sharp Tingling Achy Burning Numb Stabbing Throbbing Restricted Stiff
Rate this problem on scale 0-----10 0=No pain 10=Excruciating	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Is this getting?	Better Worse Same	Better Worse Same	Better Worse Same	Better Worse Same
What have you done to take care of this Pain/Restriction?	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 help?	Yes Partially No Slightly	Yes Partially No Slightly	Yes Partially No Slightly	Yes Partially No Slightly
Does your pain Radiate if so, Where? i.e., arm Hand, Hip, Leg, Foot	_____	_____	_____	_____
Have you had this before? <i>When?</i>	Yes No	Yes No	Yes No	Yes No
What makes your pain worse?	Bending: ___ Forward ___ Backwards ___ Left ___ Right ___ Sitting ___ Standing ___ Diving ___ Lifting	Bending: ___ Forward ___ Backwards ___ Left ___ Right ___ Sitting ___ Standing ___ Diving ___ Lifting	Bending: ___ Forward ___ Backwards ___ Left ___ Right ___ Sitting ___ Standing ___ Diving ___ Lifting	Bending: ___ Forward ___ Backwards ___ Left ___ Right ___ Sitting ___ Standing ___ Diving ___ Lifting
How does this affect your daily life in the following areas? Grade 1-10 0=No pain 10=Excruciating. 	___ Work ___ Sleep ___ Bathing/Showering ___ Dressing ___ Cooking ___ Cleaning ___ Laundry ___ Home maintenance ___ Lawn Care ___ Gardening ___ Hobbies	___ Work ___ Sleep ___ Bathing/Showering ___ Dressing ___ Cooking ___ Cleaning ___ Laundry ___ Home maintenance ___ Lawn Care ___ Gardening ___ Hobbies	___ Work ___ Sleep ___ Bathing/Showering ___ Dressing ___ Cooking ___ Cleaning ___ Laundry ___ Home maintenance ___ Lawn Care ___ Gardening ___ Hobbies	___ Work ___ Sleep ___ Bathing/Showering ___ Dressing ___ Cooking ___ Cleaning ___ Laundry ___ Home maintenance ___ Lawn Care ___ Gardening ___ Hobbies

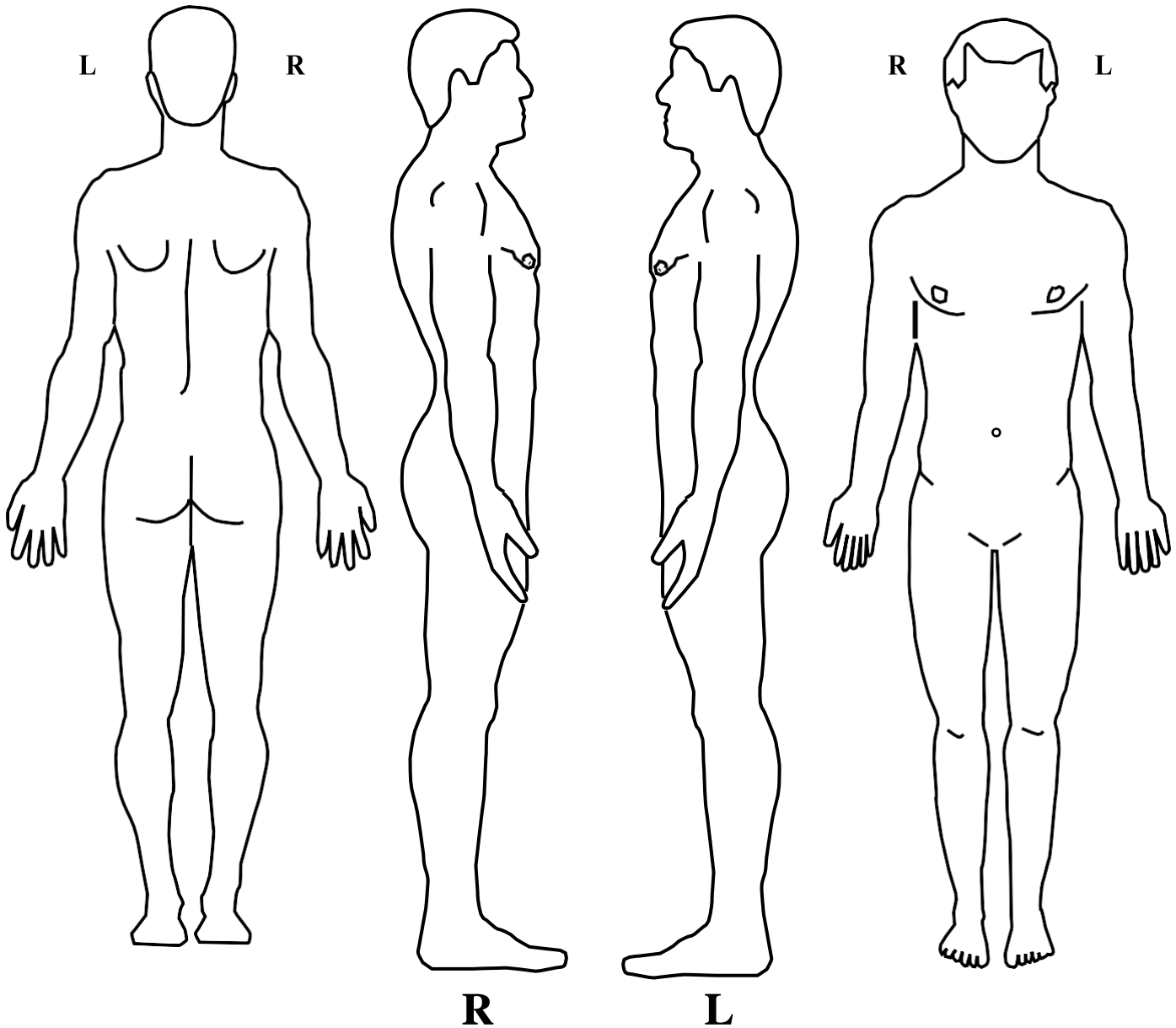
Notes: _____

Patient signature: _____ Date: _____ Reviewed: _____

PAIN DRAWING

Name _____ Date _____

Please mark where you have pain/restrictions:



Mark as follows:

A - Ache B - Burning N - Numbness P - Pins & Needles

S - Stabbing O - Other - Describe _____

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:

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.

Asheville Spine & Injury Center

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

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: _____

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Asheville, NC 28803

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

In this document, "I" and "my" refer to the patient and "Chiropractor" refers to Asheville Spine & Injury Center 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 Asheville Spine & Injury Center. 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