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 right/left	Pins and needles in arms right/left	Pins and needles in legs 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

☐ asthma	☐ COPD	☐ emphysema
☐ pulmonary embolism	☐ pneumonia	☐ tuberculosis
☐ respiratory arrest	☐ sleep apnea	☐ 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 __________________

Accident History: Please list ALL previous auto accidents or other impact injuries of note

Accident_______________________________________ Date __________________

Accident_______________________________________ Date __________________

Accident_______________________________________ Date __________________

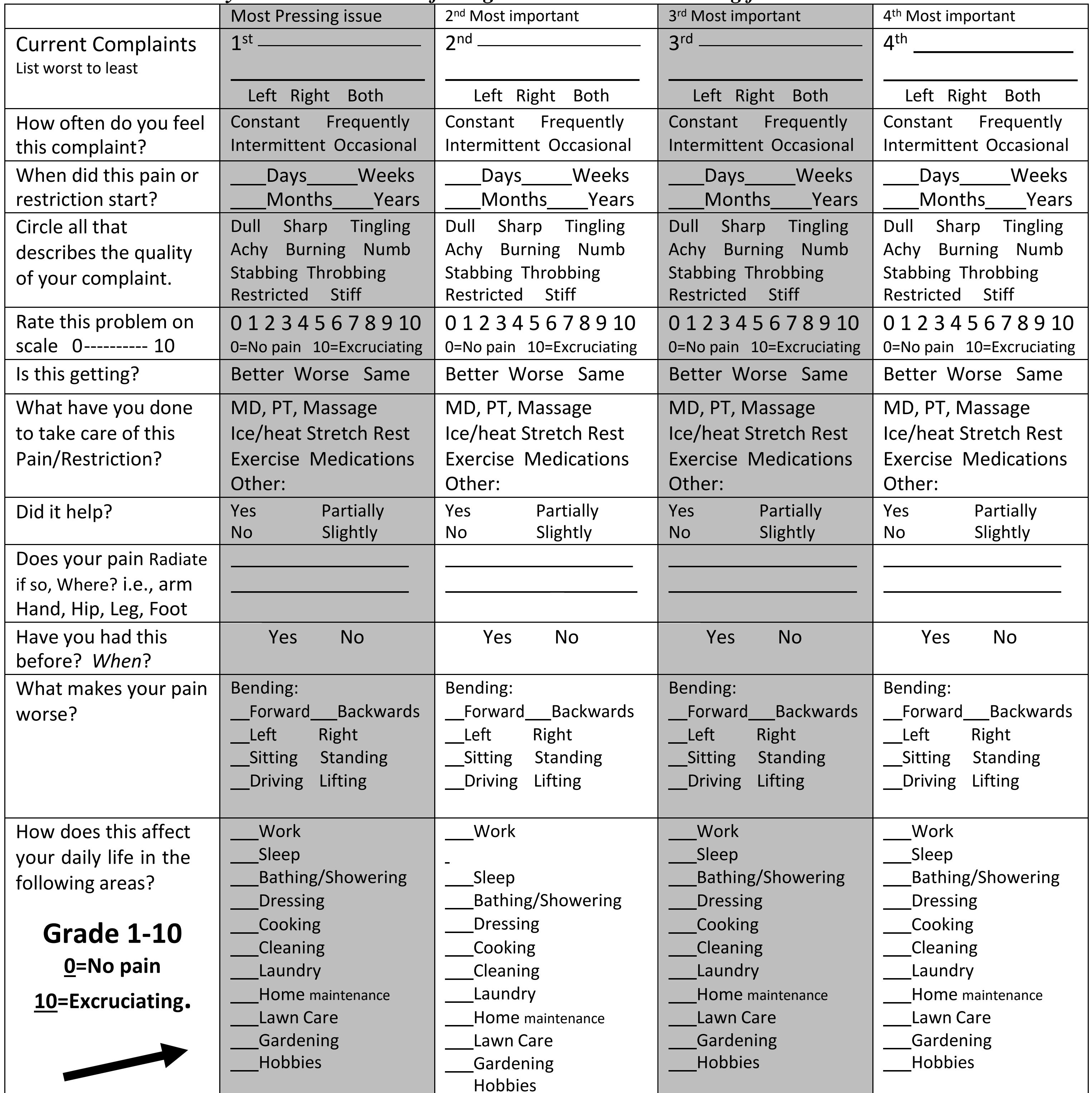
Did you go to the hospital for any of these incidents? If so, which & when ? ____________

____

Patient Signature:________________________________ Reviewed __________

Patient's Name:____ Date: ____________________

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



	Most Pressing issue	2nd Most important	3rd Most important	4th Most important
Current Complaints List worst to least	1st ______________ ________________ Left Right Both	2nd ______________ ________________ Left Right Both	3rd ______________ ________________ Left Right Both	4th ______________ ________________ 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 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
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? *When*?	Yes No	Yes No	Yes No	Yes No
What makes your pain worse?	Bending: __Forward___Backwards __Left Right __Sitting Standing __Driving Lifting	Bending: __Forward___Backwards __Left Right __Sitting Standing __Driving Lifting	Bending: __Forward___Backwards __Left Right __Sitting Standing __Driving Lifting	Bending: __Forward___Backwards __Left Right __Sitting Standing __Driving 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:____

____

____

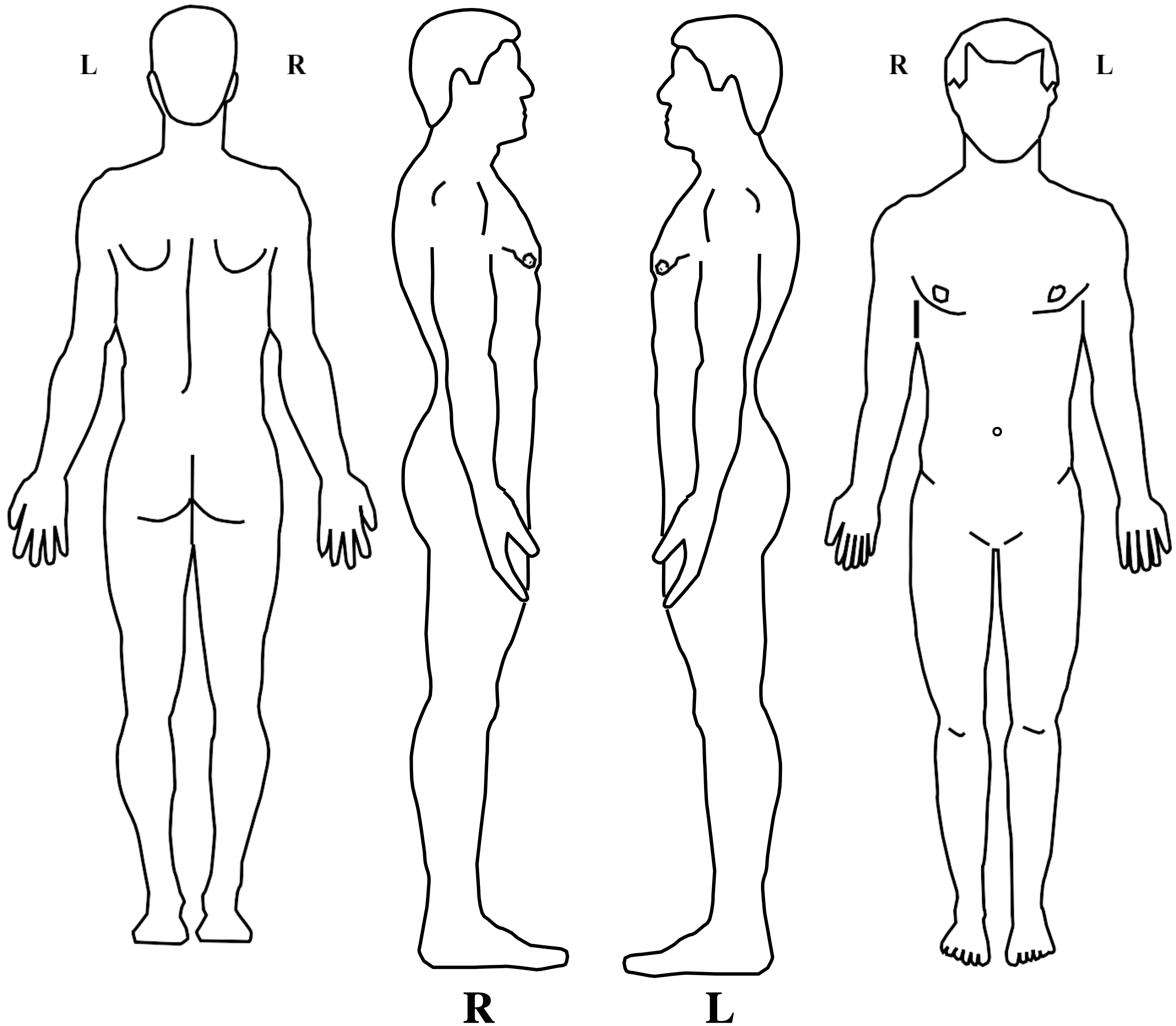
Patient signature: ______________________________ Date: ________________ Reviewed: ________

Asheville Spine & Injury Center 16 Winterwind Drive Asheville, NC 28803 (P): 829.299.4555 (F) 828.229.7151

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 mv present and future chiropractic care.

Patient's Signature:______________________________ Date:______________

Witness Signature:______________________________ Date:______________

Parent or Guardian Signature :__________________________ Date:______________

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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