NEW PATIENT INFORMATION

Welcome to our office! Please complete all fields below.

Name: ____ Date: ____________________________

Address/City/State/Zip: ____

Home Phone: ___________________ Work Phone: ___________________ Cell Phone: ___________________

Birth Date: ______________________ Age: ______ Social Security Number: ____________________________

Marital Status: ☐ M ☐ W ☐ D ☐ S ☐ O Email: ____

Your Employer: __________________________________ Occupation: ___________________________________

Spouse's Name: ______________________________ Spouse's Employer: ________________________________

Children's Names and Ages:

________________________________ _____ ________________________________ _____

________________________________ _____ ________________________________ _____

________________________________ _____ ________________________________ _____

Favorite Hobbies or Interests: ____

Method of Payment for First Visit: ☐ Cash ☐ Check ☐ Credit Card

Current health complaints / reasons for consulting our office:

1. ____

2. ____

3. ____

4. ____

Who may we thank for referring you? ____

Have you ever seen a chiropractor before? ☐ Yes ☐ No

If so, for how long? ____

Is this the result of an auto or work injury? ☐ Yes ☐ No If so, when? ___________________________________

Father, mother, brother, sister, children with similar problems? ☐ Yes ☐ No

If so, whom? ____

Other doctors you have seen for this problem: ____

Surgeries	Date
__________________________________	__________________
__________________________________	__________________
__________________________________	__________________

Medications you currently take:

Name	Dose	Frequency
________________________	_______________________	________________________
________________________	_______________________	________________________
________________________	_______________________	________________________
________________________	_______________________	________________________
________________________	_______________________	________________________

Vitamins / Supplements: ____

Is there any chance that you are pregnant? ☐ Yes ☐ No

Have you ever been diagnosed with cancer? ☐ Yes ☐ No

If so, what kind? ____

Do you have health insurance? ☐ Yes ☐ No Name of company: _______________________________________

1. All first visit charges are payable when services are rendered.

2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Creedmoor Wellness Center will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Creedmoor Wellness Center will be credited to my account upon receipt. **However**, I clearly understand and agree that I am personally responsible for payment.

In case of emergency, please notify: ____
Name of nearest relative not living with you.

Relationship: _______________________________

Address: ____

Phone number: _(_____)___________________________

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: ___________________________________ Date: _________________________

Note: Signatures on forms must be hand-signed on form that has been printed out. Thank you!

New Patient Health Issues Information

Patient Name: ____ **Date:** ___________________

<u>Problem 1:</u>

When did it start? _____________________________

Possible cause? ____

Is this problem getting: ☐ better ☐ worse ☐ constant

What makes it better? ____

What makes it worse? ____

Additional details?

____

____

____

____

____

____

____

____

Problem 2:

When did it start? ______________________________

Possible cause? ____

Is this problem getting: ☐ better ☐ worse ☐ constant

What makes it better? ____

What makes it worse? ____

Additional details?

____

____

____

____

Problem 3:

When did it start? ______________________________

Possible cause? ____

Is this problem getting: ☐ better ☐ worse ☐ constant

What makes it better? ____

What makes it worse? ____

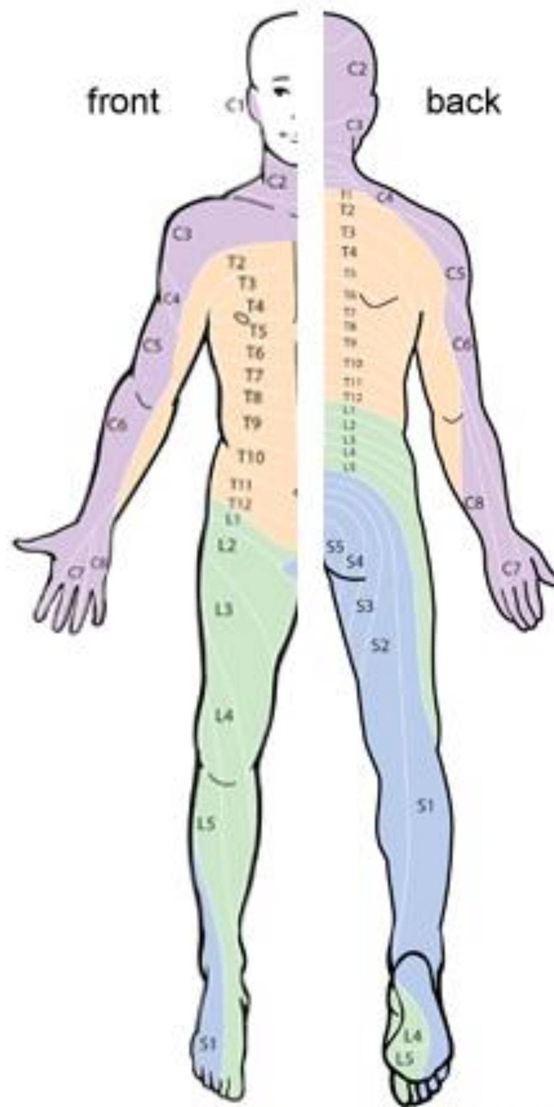
Additional details?

____

____

____

____



Please use the numbers on the body diagram above to indicate where and what type of symptoms you are experiencing. (Please also circle areas on the diagram above on printed form.)

Number of area on the above image: 1. ______ 2. ______ 3. ______

Severity of symptoms from list below: 1. ______ 2. ______ 3. ______

1-sharp 2-burning 3-dull ache 4-tingling

5-numb 6-stabbing 7-shooting 8-other

On a scale of 1-10 (1-least, 10-severe) how would you rate your

discomfort:

☐1 ☐ 2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Was the onset: ☐ sudden ☐ gradual ☐traumatic ☐unknown

What aggravates your symptoms:

☐ any movement ☐ going up stairs ☐ going down stairs ☐ sitting

☐ standing ☐turning ☐twisting ☐bending ☐ none ☐other

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)

Please list any surgeries that you have had. Please include dates if possible.

____

____

____

____

Have you ever broken any bones? ☐Y ☐N

If yes, what/when? ____

____

____

Have you been in any of the following types of accidents?

☐ auto accident ☐slip&fall ☐boating ☐motorcycle or bicycle ☐Other

List any details about any accidents:

____

____

____

____

Patient Social History and Health Habits

Please be honest! This information is confidential and very important!

Please answer all questions that apply completely, as some of these things can be very relevant to your current condition.

On a scale of 1-10 (1-least, 10-severe) how would you rate your normal stress level?

☐1 ☐ 2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

What causes you the most stress? (work, home, school, financial, other)

____

____

____

Do you practice regular prayer or meditation? ☐Y ☐N

Please tell us about some of your hobbies:

____

____

____

Do you exercise? ☐Y ☐N

If yes, what type and how often.

____

____

Please indicate your average use or consumption

Use of Type Quantity Frequency

Water __________________ __________________________

Tobacco __________________ ________________________

Alcohol __________________ _________________________

Coffee ____

Sodas __________________ __________________________

Sweets __________________ _________________________

Tea __________________ ____________________________

Recreational Drugs ___________________ ________________

Do you have specific food cravings? ☐Y ☐N

If yes, what are they?

☐ Sour ☐ Bitter _☐ Sweet ☐ Spicy ☐ Salty ☐ Other ______________________

When do they normally occur?

____

Creedmoor Wellness Center

Dr. Cheryl Hanly ~ 506 N. Main Street Creedmoor, NC 27522
919-528-7290 (p) ~ 919-528-7297 (f)

Informed Consent Form

The nature of the chiropractic adjustment

The primary treatment used by Dr. Cheryl is spinal manipulative therapy. This is the procedure that will be used to treat you. She may use her hands or a mechanical instrument upon your body in such a way as to move your joints. An ***adjustment*** is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

The material risks inherent in chiropractic adjustments

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We 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 our attention, it is your responsibility to inform our office.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bones, which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow 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 ____ have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient or Guardian Signature: ___________________________________ Date: _________________________

Note: Signatures on forms must be hand-signed on form that has been printed out. Thank you!

Consent to evaluate and adjust a minor child

I ____, being the parent or legal guardian of

____ have fully read understand the above terms of

acceptance and hereby grant permission for my child to receive chiropractic care.

______ CWC Staff

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