Account # _____

Foothills Chiropractic of Hickory, LLC 2438 N. Center St. Hickory, NC 28601 828 325-6650

Confidential Patient Information

Date _____ Name _____ Nickname if used _____
First, M.I., Last Names

Mailing Address _____ City _____ State _____ ZipCode _____
Include street type such as St., Ave., etc.

Physical Address (If different from above) _____

City _____ State _____ Zip Code _____ E-mail Address _____

Sex ____ D.O.B. _____ SS#: _____ Marital Status _____ Home Ph#(____) _____
M or F Area Code/Number

Pager (____) _____ Cell phone (____) _____ Fax (____) _____

Employer _____ Employment Info: Status: ☐ Full time ☐ Part time ☐ Retired ☐ Not employed

Work phone (____) _____ Extension _____ Work mailing address _____

City _____ State _____ Zip Code _____ Work Website _____

If Student: Status: Full time _____ Part time _____ School _____

Insurance Info: Insurance Name _____ Policy # _____ Group _____

Insurance Phone# (____) _____ Primary Insured (if different than patient) _____

Primary Insured D.O.B. _____ Primary Insured 's Mailing Address (if different than patient) _____

City _____ State _____ ZipCode _____ Primary Insured's Employer _____

Employer Mailing Address _____ City _____ State _____

Zip Code _____ Name of nearest relative (not your spouse) _____ Phone _____

Who referred you to our office? _____

Is your visit due to an accident? (Auto or work) ☐ No ☐ Yes (If yes, please see receptionist for an injury report.)

Your Present Complaint (Briefly describe your symptoms and date this condition began) _____

_____

List other doctor(s) seen for this condition _____

Medical History (if any of the following are relevant to your medical history, please check accompanying box)

☐ Stroke	☐ Hepatitis	☐ AIDS	☐ Polio
☐ Carotid Artery Disease	☐ Concussion	☐ Rheumatic Fever	☐ Digestive Disorders
☐ Dizziness	☐ Convulsions	☐ Scarlet Fever	☐ Backaches
☐ Nausea	☐ High Blood Pressure	☐ HIV/ARC	☐ Numbness
☐ Loss of Consiousness	☐ Swallowing Trouble	☐ Asthma	☐ Arthritis
☐ Visual Disturbances	☐ Balance Problems	☐ Heart Trouble	☐ Venereal Disease
☐ Pass Out Easily	☐ Numbness on one side of your face or body	☐ Cancer	☐ Diabetes
☐ Difficulty w/speech		☐ Pacemaker	

If female: Are you pregnant? ☐ Yes ☐ No. Date of last menstrual period? _____

Since your symptoms began, have you noticed a change in ☐ Bowel Function ☐ Bladder Function ☐ No Change

Please mark on your body where you have any pain or unusual sensations

On a scale of zero to 10, I rate my discomfort as follows:

Neck-Shoulder-Arm-Pain	Mid Back Pain	Low Back and Leg Pain
(_____)	(_____)	(_____)
0 no pain	0 no pain	0 no pain
10 severe pain	10 severe pain	10 severe pain

Foothills Chiropractic of Hickory, LLC, 2436 N. Center St., Hickory, NC 28601 (828) 325-5850

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Foothills Chiropractic of Hickory, LLC extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable, unless prior arrangements are made. I hereby authorize the doctors at Foothills Chiropractic of Hickory, LLC and whomever they may designate as their assistants to administer treatment as they so deem necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct. *PLEASE NOTE: There will be a $30.00 returned check fee and a $30.00 no-show fee per session.

_____ _____

Signature of Patient (Parent or Guardian if patient is under18) Date

If you have insurance, please read and sign the following:

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Foothills Chiropractic of Hickory, LLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, choice in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, choice in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provisionwithin 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured/Guardian Date

Worker's Compensation Questionnaire

Patient Name: _____ Date of birth: _____

Employer Information

Who was your employer at the time of injury? _____
Address: _____
Phone #: _____ Supervisor's name: _____
When did you report the injury? _____
Who did you report the injury to? _____
Did you fill out an accident report? ☐ Yes ☐ No Do you have a copy of report? ☐ Yes ☐ No
What is your occupation? _____
What type of work do you do? _____

Attorney Information

Have you retained an attorney? ☐ Yes ☐ No
Name of Attorney: _____
Attorney's address: _____
Attorney's Phone: _____

Accident Information

Date of Accident: _____ Time of day: _____ ☐ A.M. ☐ P.M.
Please explain in detail how your injury happened: _____
_____
_____
_____
_____
When did you feel pain? ☐ Immediately after accident ☐ later that day ☐ next day ☐ _____
Where did you feel pain? _____
Did you return to work? ☐ Yes ☐ No Date you returned to work: _____
How much time have you lost from work? _____
Did Employer send you to a doctor? ☐ Yes ☐ No Who: _____
Did you see a doctor on your own? ☐ Yes ☐ No Who: _____
What was the doctor's diagnosis? _____
What medications are you taking? _____
Do any other diseases or accidents affect your employment? _____
_____
In your work, do you have to favor any part of your body? _____
Before the injury, were you capable of working on an equal basis with others your age? ☐ Yes ☐ No
Are your work activities restricted as a result of this accident? ☐ Yes ☐ No
Have you ever injured this area before? ☐ Yes ☐ No If yes, when? _____
Have you ever had a worker's compensation claim before? ☐ Yes ☐ No If yes, when? _____
Since the injury, are your symptoms getting: ☐ Improving ☐ getting worse ☐ the same

Patient's Signature: _____ Date: _____

Account #_____

Foothills Chiropractic of Hickory, LLC

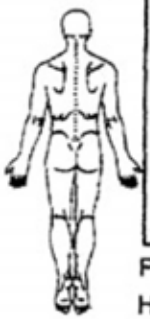
HISTORY OF PRESENT ILLNESS

PATIENT'S NAME: _____ DATE: _____

REFERRAL: _____

DOCTOR: _____ NPA: _____

MAJOR COMPLAINT: _____



HISTORY	RELEVANT TRAUMAS: ❑ Auto Accidents ❑ Slips ❑ Falls ❑ Sports
ADDITIONAL COMPLAINTS:	FAILED TREATMENT:

Previous Chiropractic treatment? ❑ Yes ❑ No What were you treated for? _____

How long were you under care?_____Approx. day since last adjustment _____

WHEN FIRST NOTICED THIS: _____

HAS IT HAPPENED BEFORE ? _____

WORSE/BETTER (A.M./P.M.): _____

ANY RADIATION OF PAIN TO AN EXTREMITY? (WHERE): _____

DOES ANY POSITION RELIEVE YOUR PAIN? (WHICH ONE?) _____

LOCATION: _____

QUALITY: ❑ Sharp ❑ Burning ❑ Aching ❑ Shooting ❑ Stabbing ❑ Dull ❑ Tingling _____

FREQUENCY (PAIN): _____

DURATION (PAIN): _____

SEVERITY (PAIN): ❑ Mild ❑ Moderate ❑ Severe _____

WHAT HAVE YOU DONE TO TRY TO HELP YOURSELF? ❑Ice ❑Heat ❑Linament ❑Exercise _____

ANY ASSOCIATED SIGNS & SYMPTOMS? _____

OTHER DOCTORS SEEN FOR THIS CONDITION: _____

ANYONE RECOMMEND MEDICATION? ❑ Yes ❑ No: MEDICATION TAKEN FOR THIS CONDITION: _____

ANYONE RECOMMEND SURGERY? ❑ Yes ❑ No: _____

DIAGNOSTIC PROCEDURES PERFORMED: ❑ MRI ❑ CAT SCAN ❑ X-RAYS Other: _____

RATED 1 TO 10 (NOW/WORST): _____

HPI Continued

SPINAL CHORD PRESSURE — Onset/Frequency/Duration/Intensity

1)	❒ past	❒ present	HEADACHES	❒ Negative
2)	❒ past	❒ present	DIZZINESS	❒ Negative
3)	❒ past	❒ present	BLURRED VISION	❒ Negative
4)	❒ past	❒ present	LOSS/CONCEN.	❒ Negative
5)	❒ past	❒ present	DEPRESSION	❒ Negative
6)	❒ past	❒ present	NERVOUSNESS	❒ Negative
7)	❒ past	❒ present	DIFFICULTY SLEEPING	❒ Negative
8)	❒ past	❒ present	LOSS OF ENERGY	❒ Negative
9)	❒ past	❒ present	TIRED A.M.	❒ Negative
10)	❒ past	❒ present	BUZZ/RING/EAR	❒ Negative
11)	❒ past	❒ present	RUN DOWN	❒ Negative
12)	❒ past	❒ present	FAINTING	❒ Negative
13)	❒ past	❒ present	PALPITATION	❒ Negative

GENERAL PROBLEMS WITH FOLLOWING

1)	❒ past	❒ present	HEAD/Ears/Nose/Throat	❒ Negative
2)	❒ past	❒ present	GLANDS/Throid/Diabetes	❒ Negative
3)	❒ past	❒ present	NECK PAIN/STIFFNESS	❒ Negative
4)	❒ past	❒ present	SHOULDER/ARM PAIN (R/L)	❒ Negative
5)	❒ past	❒ present	SKIN/Redness/Rash	❒ Negative
6)	❒ past	❒ present	UPPER BACK	❒ Negative
7)	❒ past	❒ present	MID BACK	❒ Negative
8)	❒ past	❒ present	CHEST PAIN	❒ Negative
9)	❒ past	❒ present	LUNG	❒ Negative
10)	❒ past	❒ present	HEART	❒ Negative
11)	❒ past	❒ present	STOMACH	❒ Negative
12)	❒ past	❒ present	DIGESTION	❒ Negative
13)	❒ past	❒ present	BLADDER	❒ Negative
14)	❒ past	❒ present	LIVER	❒ Negative
15)	❒ past	❒ present	KIDNEY	❒ Negative
16)	❒ past	❒ present	COLON	❒ Negative
17)	❒ past	❒ present	CONSTIPATION	❒ Negative
18)	❒ past	❒ present	LOW BACK	❒ Negative
19)	❒ past	❒ present	HIP/LEG PAIN (R/L)	❒ Negative
20)	❒ past	❒ present	POOR CIRCULATION	❒ Negative

PREVIOUS INJURIES

1) HOSPITAL/SURGERY ❒ Yes ❒ No: _____

a) IF FEMALE, BREAST REDUCTION / IMPLANTS ❒ Yes ❒ No: _____

2) ACCIDENTS (AUTO/FALLS) ❒ Yes ❒ No: _____

3) ACCIDENT ON JOB ❒ Yes ❒ No: _____

I confirm I have reviewed the information recorded here. _____ Date _____

(Dr. Signature if s/he did not take the history)

Past, Family, and/or Social History Form

Patient Name: _____ **Account Number:** _____

PAST MEDICAL HISTORY

Have you been treated by a physician for any health condition in the last year? ☐ Yes ☐ No

Describe condition _____ Date of last physical exam _____

Are you now taking any medication? ☐ Yes ☐ No What Kind?

_____

_____

Are you allergic to any medication? ☐ Yes ☐ No What Kind? _____

List all vitamins and supplements you are currently taking _____

_____

Describe any operations you've had and the dates _____

_____

FAMILY HEALTH HISTORY

Occasionally, patient's health problems and treatment response are affected by hereditary or family related spinal weakness. Please help us better understand your health and how you might respond by placing an X in the information below as it applies for all family members.

ILLNESS	Spouse	Father	Mother	Child	Child	Child	Other
Headaches							
Sinus							
Allergies							
Neck Pain							
Shoulder Pain							
Arm/Hand Pain							
Mid-back Pain							
Low-back Pain							
Hip Pain							
Leg Pain/ Numbness							
Nervousness							
Tiredness							
Neuritis							
Throat Problems							
Stiff Joints							
Asthma							
Digestive Trouble							
Diabetes							
High Blood Pressure							
Muscle Cramps							
Menstrual Pain							
Cancer							
Heart Problems							
AGE							

SOCIAL HISTORY: What are your habits? Place an X in the appropriate box.

ACTIVITY	Never	Occasionally	Moderately	Excessively
Exercise				
Alcohol				
Smoking				

What is your education level? π High School College: π 2 years π 4 years π Graduate School

Signature: _____ Date: _____

Foothills Chiropractic of Hickory, LLC 2436 N. Center St., Hickory, NC 28601
(828) 325-5850 Fax (828) 325-5852 E-mail: drbeadle90@hotmail.com

DR. E BEADLE DC, MA, CCSP, DIPL. AC (NCCAOM)

NAME: _____ DATE: _____

DIFFERENTIAL DIAGNOSIS

- What complaints / conditions do you have?
- Please list the order in which you would like these conditions treated.
- What time of the day are these conditions worse?

	Condition	Time	Re-Exam (office use only)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

(Examples include: back and neck pain, headaches, shoulder, knees, wrist, TMJ, eyes, ears, nose and throat (E ENT), heart, lung, digestive, urinary, reproductive, skin, hormone, thyroid, allergies, depression, anxiety, insomnia, lack of energy)

- In oriental medicine dreams and emotions are significant in our diagnosis.

Do you have vivid dreams? ☐ YES ☐ NO

- What emotions are most prevalent? (circle all that apply)

anger	worry	joy	panic	anxiety	sadness
tears	fear	grief	weeping	obsession	

2436 North Center Street, Hickory, NC 28601 * (828) 325-5850 * (828) 325-5852

ELIZABETH BEADLE, D.C. MA, CCSP, DIPL, AC

Patient: _____ Date: _____

S.S. #: _____ D.O.B.: _____

Authorization for Use or Disclosure of Protected Health Information:

I, the above-identified patient, or my legal representative, hereby authorizes use or disclosure of protected health information about me to be furnished to Healing for Life, PLLC at their address below, all records, x-rays, MRI reports and excerpts of all records and/or prognosis, care and treatment, billing or opinions rendered concerning any and all conditions that the above-identified patient has had in the past, may have now, and may in the future. I understand that the information used or disclosed may be subject to re-disclosure by Healing for Life, PLLC and would then no longer be protected by federal privacy regulations. This information is needed by Healing for Life, PLLC and is voluntarily disclosed by me.

I authorize the use of this medical release and any reproductions thereof to satisfy any State/Federal regulations. All records faxed are received in a secure location and will be protected/secured according to the regulations of HIPPA. I may revoke this authorization by notifying Healing for Life, PLLC in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign this authorization.

This authorization expires one year from the above date.

( ) I certify that I am the above-identified patient.

( ) I certify that I am the legal guardian of the above-identified patient.

Revocation of All Prior Authorizations:

I, hereby revoke all previous authorizations given by me for the release of medical information for any reason and/or purpose whatsoever, and specifically request that NO medical information of any nature be shown, discussed, or released to any party other than Healing for Life, PLLC; with the EXCEPTION of insurance providers and other healthcare providers as deemed necessary for the continued healthcare for the above-identified patient.

( ) I certify that I am the above-identified patient.

( ) I certify that I am the legal guardian of the above-identified patient.

X_____
Signature

2436 North Center Street Hickory, NC 28601 Phone: 828-325-5850 Fax: 828-325-5852