Dawn of Health
Chiropractic Center

CONFIDENTIAL PATIENT INFORMATION FORM

Date: _____/_____/_____ *Please answer **ALL** questions **COMPLETELY**. File # _____

Last Name: _____First:_____M.I._____

Address: _____ City: _____ State: _____ Zip Code:_____

Phone Home _____-_____-_____Work:_____-_____-_____ Cell Phone _____-_____-_____ Text Reminders: Y/N

Occupation: _____Employer's Name _____

Employer's Address: _____ City:_____ State:_____ Zip Code:_____

Date of Birth: _____/_____/_____ Age: _____ Gender: ☐M ☐F

How Did You Hear about Us, or Whom May We Thank For Referring You: _____

E-mail: _____ Receive our monthly newsletter (you can cancel anytime) Yes No

Please Check Type of Payment: ☐ Cash ☐ Check ☐ Master Card/Visa ☐ Debit Card

If a Student, please list parent's residence: _____

Please circle the status that applies: Single Dating Engaged Married Divorced Widowed Separated

Children's Names & Ages:_____

Spouse/Parent Last Name: _____ First Name: _____ Middle: _____

D/O/B: _____/_____/_____

Spouse's Employer: _____ Occupation: _____

Cell # _____-_____-_____Work # _____- _____- _____ Ext: _____ Work Hours:_____

Nearest Relative or Emergency Contact Person: _____Phone #: _____-_____-_____

If you are seeking care due to an Auto or Work Accident please ask the front Desk for Additional Paperwork at this time. Check One Below:

Please Check: ☐ Auto Accident ☐ Worker Compensation Date When Accident Occurred: _____/_____/_____ _____:_____ Am / Pm

☐ I am ☐ I am not seeking care due to an auto or work injury. **Initial here: _____**

Insurance Information

Do You Have Health Insurance: ☐ Yes ☐ No Secondary Insurance Coverage: ☐ Yes ☐ No

Do You Have Medicare: ☐ Yes ☐ No Do You Have Medicaid: ☐ Yes ☐ No

I understand and agree the health and accident insurance policy: I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. We file insurance claims as a courtesy to our patients and we will help you receive maximum benefits. **However, Insurance is a contract between you and your insurance company. We are NOT a party to this contract**. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, coverage charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. **YOU ARE ULTIMATLY RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT. If we receive the reimbursement check, we will apply a credit for future services OR we will write you a check on your next visit. We will not mail reimbursements.**

Patient's Signature: _____ Date: _____/_____/_____

Guardian's Signature (For Minors): _____ Date: _____/_____/_____

Notice to Our New Patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangement must be made in advance before seeing the doctor.

REVIEW OF SYSTEMS

Name: _____ Date: _____ File #: _____

Please check **ALL** symptoms which you are **Currently Suffering** or **Have Suffered**.

Medical Conditions:

	Present	Past	No
Cardiovascular			
Aortic Aneurism			
High Blood Pressure			
Hypertension			
High Cholesterol			
Heart disease 402			
Heart Attack			
Chest pain 786.50			
Chest pain- anxiety			
Poor Circulation			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of legs			
Heart- rapid beat			
Heart-Slow beat			
Vascular Disease			
Varicose veins			
Neurological			
Stroke			
Seizures 345.9			
Head injury/Whiplash			
Brain Aneurysm			
Numbness 782.0			
Severe Headaches 784.0			
Migraines- Cluster 346.1			
Pinched Nerves			
Parkinson's Disease 332.0			
Carpal Tunnel			
Spinning/Balance			
Tingling			
Phantom Pains 353.6			
Restless leg syndrome			
Loss of sleep 780.50			
Twitching			
Musculoskeletal			
Gout			
Arthritis 721.0			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joint Replacement			
Neck-stiffness/pain 723.1			
Mid Back Pain 724.1			
Lower Back Pain 724.2			
Hip Pain			
Painful tailbone			
Scoliosis			
Hand Wrist Pain			
Muscle Aches			
Psychiatric			
Depression			
Anxiety Disorder			
Unusual Stress			

	Present	Past	No
Respiratory			
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			
Spit up phlegm			
Ears/Nose/Throat			
Dizziness 780.4			
Hearing Loss/Tinnitus			
Sinus Infection			
Nose Bleeds			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			
Ear infection 381.3			
Hoarseness			
Dry			
Heart Burn 530.1			
Gastrointestinal			
Gallbladder Problems			
Bowel Problems			
Constipation 564.0			
Liver Problems			
Ulcers			
Diarrhea 787.91			
Nausea/Vomiting 787.02			
Bloody Stools			
Poor Appetite			
Irritable bowel 564.1			
Stomach pains			
Hemorrhoids 455			
Hernia			
Gas or Belching			
Endocrine			
Thyroid Disease			
Diabetes 253.5			
Hair Loss			
Weight Loss			
Weight Gain			
Difficulty Sleeping			
Fatigue 780.7			
Cancer			
Breast Cancer 174.8			
Bone Cancer			
Lung Cancer			
Prostate Cancer			
Skin Cancer			
Colon Cancer			
Women Only			

	Present	Past	No
Genitourinary			
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in Urine			
Kidney Stone			
Kidney Infection			
Hematological/Lymphatic			
Hepatitis			
Blood Clots			
Chills 780.6			
Fever/Sweats 780.6			
Easy Bruising			
Easy Bleeding			
Stroke			
Allergic/ Immunological			
Hives			
Immune Disorder			
HIV/AIDS 042.9			
Allergy Shots			
Cortisone Use			
Skin Lesions			
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			
Skin disorder			
Skin-Dryness			
Skin-itching			
Skin- Sensitive			
Eyes			
Glaucoma			
Double Vision			
Blurred Vision			
Nearsighted			
Farsighted			
Women Only			
Menopausal			
Menstrual Problems			
Vaginal- Itch			
Cyst-ovarian 620.2			
Breast lump/bruising 174.8			
Painful Cramps			
Hot Flashes			
Men Only			
Erectile Dysfunction			
Prostate Problems			

Addition Note:

Date of Last Menstrual Period/Cycle: _____

Date of Last Pap Smear_____

Name of Physician:_____

To your Knowledge are you pregnant? Yes or No

Patient's Signature: _____ *Doctor's Signature:* _____ *Date;* _____

REVIEW OF CURRENT COMPLAINT

Name: _____ Date: _____ Age: _____

- Describe Your Health Problem(s) or Concern(s) In Which You Are Seeking Care For:

_____

_____

- When did your symptoms begin? _____
- Can you think of anything that may have caused / contributed to your problem (***No matter how long ago***)?

_____

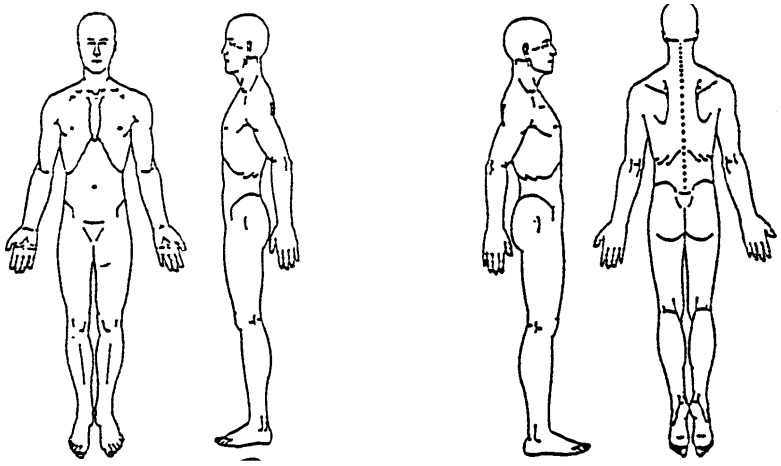
_____

- **How often** do you experience your Symptoms?

☐ Intermittent (less than 25% of the time while awake) ☐ Occasional (between 25% to 50% of the time)

☐ Frequent (between 50% and 75% of the time) ☐ Constantly (between 75% to 100% of the time)

***Please Place an "X" on the Area of Complaint on the diagram.**



Average Pain experienced in the past 4 weeks

Circle Pain Level

No Pain 0--1--2--3--4--5--6--7--8--9—10 intolerable

Describe the Pain is it:

Sharp, Dull ache, Numb, Shooting, Deep, Burning, Tingling, Sharp on Movement, Stabbing, Cramping, Pinprick, Radiating,

- **Since the complaint began are you getting**? ☐ Better ☐ Worse ☐ No Change
- **How much has the pain interfered with your normal work** (including work inside and outside the home)?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

- Is the **Pain Aggravated / worsened** by: ☐ Coughing ☐ Sneezing ☐ Straining using the bathroom

☐ Neck movement ☐ Reaching ☐ Lifting ☐ Bending ☐ Sitting ☐ Standing ☐ Walking

- Have **you suffered with this problem before**? Yes or No

If "yes" who have you seen for symptoms? ☐ No one ☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist

- Have You Had **Recent Treatment For this Problem**? Yes or No

Providers Seen During Last 12 Months

I understand that some insurance policies have pre-existing condition clauses and they will, prior to paying your claim request this information. Without this information your insurance company may not pay our office. Once requested, I understand this information will be forwarded to my health insurance company in order to assure payment to our office.

Provider(s) Name & Clinic	Date Treated	Reason for treatment

(Use Back of this sheet if needed)

Patient's Signature: _____ *Doctor's Signature:* _____ *Date;* _____

REVIEW OF HEALTH HISTORY

Name: _____ Date: _____ File #: _____

Name of your family Physician and Date of last visit? _____

Have you been hospitalized in the past? ☐ Yes ☐ No

If "Yes" Name of Hospital, date & Reason: _____

_____

Have you had surgery in the past? ☐ Yes ☐ No

If "Yes" Name of Doctor, date & Reason: _____

_____

Have you had any accidents or traumas in the past (serious or Minor)? ☐ Yes ☐ No

If "Yes" Date & what happened: _____

_____

No Healthy Person Should Be Taking Medication!!! Are you currently taking any Medication? "This includes Aspirin, NSAIDS, ect."

Medication	Amount/Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: _____

Stress History

Childhood:

Repeated/Prolonged Antibiotic use	YES	NO	Inhaler Use	YES	NO
Car Accident	YES	NO	Prescription Medications	YES	NO
Childhood Illness	YES	NO	Surgery	YES	NO
Fall/Jump from a Height of < 3 ft.	YES	NO	Vaccinations	YES	NO
Fall/Jump from a Height of > 3 ft.	YES	NO	Youth Sports	YES	NO
Head Trauma	YES	NO	Other Traumas (physical or emotional _____		

Adulthood:

Alcohol: Drinks/Day _____	YES	NO	Fall/Jump from a height	YES	NO
Smoker: Packs/Day_____	YES	NO	Head Trauma	YES	NO
Drug Use/Abuse	YES	NO	Surgery	YES	NO
Prescription Medications	YES	NO	Contact Sports	YES	NO
Inhaler Use	YES	NO	Extreme Sports	YES	NO
Repeated/Prolonged Antibiotic use	YES	NO	Home or Workplace Stress	YES	NO
Car Accident	YES	NO	Other Trauma (physical or emotional)_____		
Coffee Drinker: Cups/day_____	YES	NO	_____		

Yes? Please Explain_____

_____

Supplements Taking and Why? _____

I declare that all of the above information is true and correct to the best of my knowledge.

Patient's Signature: _____ Date: _____/_____/_____

Guardian's Signature (For Minors): _____ Date: _____/_____/_____

*Doctor's Signature:*_____ *Date:* _____

DAWN OF HEALTH CHIROPRACTIC, PLLC
1011 W. Williams St. Suite 104
Apex, NC 27502

919.303.2213 office/ 919.303.0332 fax

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Dawn of Health Chiropractic, PLLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. This is located on our website under online forms or in the office at the front desk and in the Patient Success Stories Binder.
I acknowledge receipt of a copy of the office Notice of Patient Privacy Policy

Signature:_____ **Date:** _____

Appointment Reminders and Email notifications: Appointment reminders and private health information will be communicated to you only in the manners in which you have given specific written authorization and you have the option to opt out of any of those methods at any time by notifying our office. Email and standard SMS/text messaging are not confidential methods of communication and may be insecure.
_____***(initials) I authorize Dawn of Health Chiropractic to contact me via text or email to provide appointment reminders or information about treatment alternatives or other health related benefits or services***

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

Dawn of Health
Chiropractic Center
Dr. James Strunk, D.C.
1011 W. Williams Street, Suite 104
Apex, NC 27502
919-303-2213

Informed Consent

I, _____, hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above.

I have had an opportunity to discuss with the doctor named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and I am informed that in the practice of chiropractic, as in the practice of medicine, there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I trust the doctor to exercise judgment during the course of the procedures in which the doctor feels is in my best interest based upon the facts then known to him or her.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of care for my present condition and for any future condition(s) for which I seek care.

Patient Signature_____ Date _____

OR

Legal Guardian Signature_____ Date _____

Consent to evaluate and adjust a minor child

I, _____being the parent or legal guardian of _____ have read and fully understand the above consent and grant permission for my child to receive care by above doctor.

Policy Statement

SERVICES

Dawn of Health and Atlas Chiropractic provide Upper Cervical and gentle, low force chiropractic care, examinations, thermographic studies and x-rays procedures. Services are provided by qualified and licensed practitioners, in accordance with professional standards applicable to our profession and in accordance with the laws and statues of North Carolina. Please help us to serve you better by keeping scheduled appointments. It is **beneficial to your restoration of health that all appointments are kept as set by the doctor.**

HOURS

Our patient hours are Mon and Thurs 9am – 12pm / 3pm - 6pm, Tuesday 2:30 – 6pm, Wed 9am-12pm / 1:30 – 4pm, Friday 9am-12pm. We as healthcare providers understand that things may come up unexpectedly. We ask that if there is a conflict in your scheduled appointment time**, you call us within 24 hours to ensure we have slots available for our other patients.** Patients, who miss appointments, without calling in advance, will have **a $50 missed appointment fee** charged to their account. If you arrive late to your appointment, you may be subject to waiting until the next open slot is available.

CONFIDENTIALITY

Services and communications between patients and providers will be kept confidential. A confidentiality exception could be made upon request for appropriate information regarding payment of services by third parties, harm to self or others, and suspected child or elder abuse. Dawn of Health and Atlas Chiropractic welcomes you to the office and will send special cards or letters in honor of a birthday, anniversary, etc. If you do not wish to receive any mailings from our office, you need to make it known to our office manager in writing.

FEES AND EXPENSES

Office Visit (no adjustment): $50
Adjustment: $60 (*Prepay 10 visits and receive an 11th visit/service of equal value at no charge*)
Medicare Spinal and/or Extremity Adjustment/Visit: $45 (Medicare rules apply)
Laser Therapy: $40 (*Package of 10 at $400, receive an 11 th at no charge*)
Spinal Decompression: $60 (*Prepay 10 visits and receive an 11th visit/service of equal value at no charge*)

The patient, or the adult responsible for a minor patient, is responsible for payment at the time of service. Payment can be pre-paid, and is expected to be paid in full. Any unpaid accounts will be subject to collection procedures.

We file insurance claims as a courtesy to our patients and we will help you receive maximum benefits. **However, Insurance is a contract between you and your insurance company. We are NOT a party to this contract**. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, coverage charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. **YOU ARE ULTIMATLY RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT. If we receive the reimbursement check, we will apply a credit for future services OR we will write you a check on your next visit. We will not mail reimbursements.**

Charge for Copying Records: All requested reports regarding records to courts, attorneys, workers compensation claims, medical facilities, schools, etc. will be charged at $20.00 for pages 1-20, $1.00/ page for the next 80 pages, $.50 after that, plus postage and handling according to state regulations. Insurance companies will not pay for this charge. The fee for a returned check is $25.00 and that bill must be paid with a cashier's check, credit card or cash.

I have read and understand the above policy statement:

Signature_____ **Date**_____