Beaufort Chiropractic

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in cause and prevention of disease" -Thomas Edison

Patient Information: (Please Print in Ink)

Name: _____ Date: _____
First Middle Initial Last Name

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

Sex: ☐ Male ☐ Female Birthdate: _____ Email: _____

Phone: H: _____ C: _____ W: _____

Do You Prefer to Receive calls at: ☐ Home ☐ Work ☐ Cell ☐ No Preference

Status: ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered

Patient Employer/School: _____ Occupation: _____

Spouse/Parent's Name: _____ Occupation: _____

Whom May We Thank for Referring You to Us? _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (_____) _____

Symptoms:

Reason For Visit: _____ When did symptoms begin? _____

Is this Condition Getting Progressively Worse? _____

Where specifically is the problem(s) located? _____

Which Activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending
☐ Lying Down ☐ Other _____

Type of Pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness	☐ Aching	☐ Shooting
☐ Burning	☐ Tingling	☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other_____

Rate Severity of Pain (1 = Mild Pain/Discomfort to 10 = Severe Pain): (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

Is the pain constant or does it come and go? _____

What treatment have you already done for this condition? ☐ Medication ☐ Surgery
☐ Physical Therapy ☐ Other: _____

Name/Address of Doctor who treated you: _____

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Birth History:

Did your mother have a difficult Pregnancy with you? ☐ Yes ☐ No

Was your Birth traumatic? ☐ Yes ☐ No

My Birth was at: ☐ Home ☐ Hospital ☐ Birth Center ☐ Other _____

Were you incubated or isolated at Birth? ☐ Yes ☐ No

Was your Birth: ☐ Natural ☐ Drug Induced ☐ Forceps/Suction Used ☐ C-Section
☐ Cord Around Your Neck ☐ Breech ☐ Prolonged ☐ Other: _____

Did your Mother Consume Alcohol during pregnancy**?** ☐ Yes ☐ No

Was Your Mother subjected to Chemical Stresses? ☐ Yes ☐ No

Explain: _____

Were you Fed: ☐ Formula ☐ Bottle Fed ☐ Mother's Milk ☐ Nursed ☐ Nursed and Bottle Fed

General Physical Trauma:

	Mild		Moderate		Extreme	
	Past	**Present**	**Past**	**Present**	**Past**	**Present**
Falls	☐	☐	☐	☐	☐	☐
Sports Impacts	☐	☐	☐	☐	☐	☐
Physical Fight	☐	☐	☐	☐	☐	☐
Armed Services	☐	☐	☐	☐	☐	☐

Have you ever injured your spine (Neck, Head, Back, Hips)? ☐ Yes ☐ No

Date of Most Significant Injury? _____

What Happened? _____

Date of Most Recent Injury? _____

What Happened? _____

Have you broken any bones or significantly sprained part of your body? ☐ Yes ☐ No
Explain: _____

Have you ever been knocked unconscious? ☐ Yes ☐ No

Explain: _____

Have you had extensive dental or orthodontic work perform? ☐ Yes ☐ No

Explain: _____

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Medical History:

Have you ever been hospitalized? ☐ Yes ☐ No

If yes, please explain: _____

Have you had surgery? ☐ Yes ☐ No

If yes, please explain: _____

Have you had any spinal x-rays, CAT scans or MRI imaging of your spine, head, neck, back or hips?

☐ Yes ☐ No When? _____

What were you told about them? _____

Have you consulted a physician or other health care provider in the past three months? ☐ Yes ☐ No

What was the reason for the visit? _____

When was your last visit? _____ What was done or suggested? _____

Health History:

Are you taking the following Medications:

☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ Stimulants

☐ Blood Thinners ☐ Tranquilizers ☐ Blood Pressure Medication ☐ Insulin

☐ Antidepressants ☐ Other _____

Are you now taking any drug (prescription or over the counter) regularly? ☐ Yes ☐ No

If yes, please list drugs, when prescribed and reasons for taking them:

_____

Did a physician prescribe these drugs? ☐ Yes ☐ No Date of Last Visit: _____

Were you previously taking any medications regularly? ☐ Yes ☐ No

Have you been immunized? ☐ Yes ☐ No

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Please Check All That Apply:

- ☐ AIDS/HIV
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Anorexia
- ☐ Alcoholism
- ☐ Allergy-Shots
- ☐ Alzheimer's Disease
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Artificial Valves
- ☐ Artificial Limbs/Joints
- ☐ Asthma
- ☐ Autism
- ☐ Autoimmune Disorder
- ☐ Balance Problems
- ☐ Bleeding Disorders
- ☐ Bladder Disease
- ☐ Blood Clots
- ☐ Blood Disease
- ☐ Blood in Urine
- ☐ Bone Disease
- ☐ Bowel Disorder
- ☐ Breast Lumps
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Changes in Stool Color
- ☐ Chemical Dependency
- ☐ Chemotherapy/Radiation
- ☐ Chest Pain/Conditions
- ☐ Chicken Pox
- ☐ Chron's Disease
- ☐ Cold Extremities
- ☐ Colonitis
- ☐ Congenital Heart Disease
- ☐ Corrective Lenses
- ☐ Covid
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Difficulty Holding Urine
- ☐ Difficulty Starting/Stopping the Flow of Urine
- ☐ Digestive Problems
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Endocrine disease
- ☐ Epilepsy
- ☐ Excessive Menstruation
- ☐ Excessive Sweating
- ☐ Excessive Gas
- ☐ Fatigue
- ☐ Floating Stools
- ☐ Fractures
- ☐ Frequent Neck Pain
- ☐ Gallbladder Issues
- ☐ Gallbladder Stones
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Hardening of Arteries
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Irregular Heartbeat
- ☐ Kidney Disease
- ☐ Kidney Infection
- ☐ Kidney Stone
- ☐ Liver Disease
- ☐ Loss of Memory
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Low Back Pain
- ☐ Low Blood Pressure
- ☐ Lumps in Breast
- ☐ Lung disease
- ☐ Male Reproductive Disorder(s)
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mitral Valve Prolapse
- ☐ Mononucleosis
- ☐ Mood Swings
- ☐ Multiple Sclerosis
- ☐ Musculoskeletal Disorder(s)
- ☐ Mumps
- ☐ Nausea/Vomiting
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Neurological Disorder
- ☐ Nosebleeds
- ☐ Numbness/Tingling
- ☐ Osteoporosis/Osteopenia
- ☐ Pacemaker
- ☐ Painful Urination
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rashes
- ☐ Reflux
- ☐ Rheumatoid Arthritis
- ☐ Ringing Ears
- ☐ Scarlett Fever
- ☐ Sciatica
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Skin Disorders
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Stress/Tension
- ☐ Suicide Attempt
- ☐ Swelling of Abdomen
- ☐ Swelling of Hands/Feet/Ankles
- ☐ Swollen Joints
- ☐ Tenderness/Swelling in Calf or Thigh
- ☐ Thyroid problems
- ☐ Tonsilitis

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Continued…

- ☐ Trouble Hearing
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Vaginal Disease
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Vision Problems
- ☐ Weakness
- ☐ Whooping Cough
- ☐ Other _____

Dates of Last Exams? _____

(Women) Are You Pregnant? ☐ Yes ☐ No
(Women) Are You Nursing? ☐ Yes ☐ No
(Women) Are You taking Birth Control? ☐ Yes ☐ No

Allergies: _____

Daily Habits:

What type of exercise do you perform daily? ☐ None ☐ Moderate ☐ Heavy

What does your daily work habits include? (Sitting, Standing, Light Labor, Heavy Labor, Computer Work)

_____

What kind of vitamins/nutritional supplements do you currently take (if any)? _____

_____

Do You Smoke? ☐ Yes ☐ No How much per day _____

How much alcohol do you consume on a weekly basis? _____

Do you use artificial sweeteners? ☐ Yes ☐ No If yes, what kind? _____

How much coffee or caffeinated beverages do you consume daily? _____

Do you drink sodas? ☐ Yes ☐ No If Yes, How Much? _____

What Kind? _____

How much water do you drink daily? _____

Experience with Chiropractic:

Have you ever been adjusted by a chiropractor? ☐ Yes ☐ No

Reasons for those visits? _____

Doctor's Name? _____

Approximate Date of Last Visit _____

Has any adult in your family seen a chiropractor? ☐ Yes ☐ No

Has any child in your family seen a chiropractor? ☐ Yes ☐ No

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Awareness of Chiropractic Principles

Were you aware that:

Doctor of Chiropractic work with the nervous system? ☐ Yes ☐ No

The nervous system controls all bodily functions and systems? ☐ Yes ☐ No

Chiropractic is the largest natural healing profession in the world ☐ Yes ☐ No

If chiropractic care starts at birth, you can achieve a higher level of health throughout your life?

☐ Yes ☐ No

Goals For My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, and others for correction of whatever is malfunctioning in their bodies. Dr. Sams will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes, whenever possible.

☐ Relief Care – Symptomatic relief of pain or discomfort
☐ Corrective Care – Correcting and relieving the cause of the problem as well as the symptoms
☐ Comprehensive Care – Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care
☐ I want the Doctor to select the type of care appropriate for my condition

_____ _____

Patient's Signature Date

Authorization to Release Information:

I authorize the doctor and his/her staff to release any information deemed appropriate concerning my physical condition and treatment to any Insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a Photostat copy of the agreement shall serve as the original.

_____ _____

Patient's Signature Date

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Authorization for Care:

I hereby authorize Dr. Sams to work with my condition through the use of adjustments to my spine as she deems appropriate.

I clearly understand and agree that payment is due at the rime services are rendered. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed condition nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment for my insurance rights and benefits (if applicable) directly to the provider of services rendered.

_____ _____

Patient's Signature Date

Cancellation Policy:

Cancellations must be made 24 hours in advance of scheduled visit or the office visit charge will be billed to your account.

About my Insurance: (For Medicare Patients Only)

I understand and agree that Medicare coverage is an arrangement between Medicare and me. I understand that the Doctor's office will prepare any necessary reports and forms to assist me in collecting from Medicare and that any amount authorized by Medicare reimbursement will be paid directly to me.

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Our Partnership for Healing

True healing is a process. Our relationship as Doctor and Patient is a partnership where the rate of healing is totally dependent on both of us bringing all that we can bring. I covenant to you the very best care I can deliver. You can help facilitate this healing process by honoring your own plan of care, being on time for your appointments and knowing that this type of healing is not a quick fix, but a journey we both elect to take.

Thank you for trusting me with your care.

I look forward to building and maintaining a healthy relationship!

_____ _____

Patient/Guardian Date

_____ _____

Doctors Signature Date

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: 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.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. Subluxations can be caused by emotional, chemical or physical stresses/traumas; thus we may recommend supportive healing options to help you hold your adjustments and express optimum health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

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/Guardian Signature Date

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Consent to Evaluate and Adjust a Minor Child:

I, _____ being the parent or legal guardian of_____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____

Parent/Guardian Date

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant, and the above doctor and her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

_____ _____

Patient/Guardian Date

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HIPAA Consent/Authorization of Use & Disclosure of PHI/Notice of Privacy

Patient Name:_____ Date of Birth: _____

Authorization to Release Medical and Appointment Information

I give my permission to release any of my PHI (Protected Health Information) to the names below. Without this authorization, I will not be able to disclose any information about you, your appointment, your bill(s), or your treatment in my office to anyone but you, the patient, your insurance company or referring/treating physician(s).

Name:	**Relationship to You:**	**Type of Information to Release** (All, Appointment, Treatment, Financial)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Contact Information

May we contact you and leave information regarding appointments, treatment as well other pertinent medical information in the following methods listed below? ☐ Yes ☐ No

If Yes, Please Check All That Apply:

☐ Home Phone ☐ Answering Machine/Voicemail ☐ Work Phone ☐ Mail

☐ Cell Phone ☐ Text Message ☐ Email

_____ _____

Patient/Guardian Signature Date