



122 S. Goose Creek Blvd, Ste B
Goose Creek, SC 29445
P: 843.553.2211 F: 843.553.2210

WELCOME

PATIENT INFORMATION

Date: _____

Name: _____
First Middle Last

Mailing Address: _____
Street Name

City State Zip Code

Phone # (H) _____ (W) _____ (Other) _____

What number do you prefer us call? Home Work Other

Email address: _____

Date of Birth: ____/____/____ Sex: Male Female SS#: _____

Marital Status: Single Married Divorced Widowed Separated Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

Emergency contact: Name: _____ Relation: _____

Phone # (H) _____ (W) _____ (Other) _____

How did you hear about our practice? _____

ACCIDENT INFORMATION

Is this visit due to an accident? Yes No If yes, what type? Auto Work Other _____

Has it been reported? Yes No If yes, to whom? _____

FINANCIAL INFORMATION

Policy Holders Name: _____

Policy Holders Date of Birth: ____/____/____ Relationship to patient: _____ Phone # _____

Policy Holders Address (If different from patient): _____

Do you have health insurance? Yes No Name of Carrier: _____

Do you have secondary insurance? Yes No Name of Carrier: _____

ASSIGNMENT AND RELEASE (Insured Patients)

I certify that I (or my dependent) have insurance coverage, stated above, and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, Advantage Healthcare of Charleston LLC., INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. 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, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Patient Name (Signature)

Date

Patient Name: _____ DOB: __/__/____ Date: __/__/____

PATIENT DEMOGRAPHICS

As a medical office we are required to report patient demographics to insurance agencies as requested. Please answer the following questions.

Primary Language: _____ Secondary Language (if applicable): _____

Ethnicity: Hispanic or Latino Non Hispanic or Non Latino Decline to Specify

Smoking: Current Everyday Smoker Current Someday Smoker Ex-Smoker Heavy Tobacco Smoker
Light Tobacco Smoker Never Smoked Tobacco Smoker, Current Status Unknown Unknown if ever smoked
Smoking Start Date: _____

Next of Kin:
First: _____ Last Name: _____
Relationship: _____
Address: _____ (City) _____ (State) _____ (Zip) _____
Contact Number: _____ Contact Type (Home, Cell, Work, Etc.) _____

FAMILY HISTORY

The following questions should be answered ONLY if one of your immediate family members has experienced one of these conditions/diseases. Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

- Heart Disease _____ Diabetes _____
- Cancer _____ Arthritis _____ Other _____

HEALTH HISTORY

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you have ever had any of the following:

- Aids/HIV Cancer Hepatitis Osteoporosis Stroke
- Alcoholism Cataracts Hernia Pacemaker Suicide Attempt
- Allergy Shots Chemical Dependency Herniated Disc Parkinson's Disease Thyroid Problems
- Anemia Chicken Pox Herpes Pinched Nerve Tonsillitis
- Anorexia Diabetes High Cholesterol Pneumonia Tuberculosis
- Appendicitis Emphysema Kidney Disease Polio Tumors/Growths
- Arthritis Epilepsy Liver Disease Prostate Problems Typhoid Fever
- Asthma Fractures Measles Prosthesis Ulcers
- Bleeding Disorders Glaucoma Migraines Psychiatric Care Vaginal Infections
- Breast Lump Goiter Miscarriage Rheumatoid Arthritis Venereal Disease
- Bronchitis Gonorrhea Mononucleosis Rheumatic Fever Whooping Cough
- Bulimia Gout Multiple Sclerosis Scarlet Fever
- Heart Disease Mumps Other _____

Are you currently under drug and/or medical care? Yes No If yes, explain: _____

Please list any medications you are currently taking, including supplements: _____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

Please list any allergies: _____

Do you exercise: Frequently Moderately Occasionally None
Do your work activities mostly involve: Sitting Standing Light Labor Heavy Labor
Do you sleep on your: Back Side Stomach Do you use a cervical pillow? Yes No

What is your daily/weekly intake of the following? Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _ packs/day

Patient Name: _____ DOB: ___/___/___ Date: ___/___/___

REVIEW OF SYSTEMS

- Allergic-Immunologic:** None known
 Hives/Eczema Hay Fever Catch Colds Easily Frequent Sinus Trouble Frequent Influenza
 HIV AIDS Fever Allergies (if yes please list below)

Please list any allergies: _____

- Cardiovascular:** None known
 Murmur Chest Pain Palpitations Dizziness Shortness of Breath
 Swollen Ankles Heart Attack Irregular Heart Beat Pressure Over the Chest Pain Down the Left Arm
 High Triglycerides High Cholesterol Profuse Sweating Nausea Vomiting
 Low Blood Pressure Fainting Spells High Blood Pressure Difficulty lying flat

- Constitutional:** None known
 Weight Loss Fatigue Fever

- Ear, Nose, Throat:** None Known
 Difficulty Hearing Buzzing in Ears Ringing in Ears Vertigo Sinus Trouble Nasal Stuffiness
 Hearing Loss Ear Pain Mouth Sores Hearsens Nose Bleeds Dental Problem
 Frequent Sore Throat Difficulty Swallowing

- Endocrine:** None Known
 Loss of Hair Heat/Cold Intolerance Hypothyroidism Hyperthyroidism Diabetes Goiter

- Eyes:** None Known
 Glasses/Contacts Eye Pain Light Bothers Eyes Double Vision Cataracts Vision Problems
 Blurred Vision Glaucoma

- Gastro-Intestinal:** None Known
 Heartburn/Reflux Nausea/Vomiting Constipation Change in BMs Diarrhea
 Black/Bloody BM Gallbladder Problem Liver Problem Hepatitis Distress from greasy food
 Ulcers Heartburn Hiatal Hernia Colitis Blood in Stool
 Colon Cancer Abdominal Pain Burning in Stomach Pancreatitis Jaundice
 Pain over Stomach Mucus in Stool

- Genitourinary:** None Known
 Burning/Frequency Blood in Urine Erectile Dysfunction Abnormal Discharge Leakage
 Incontinence Kidney Infection Sexual Difficulty Kidney Stones Loss of Libido

- Hematology/Lymp:** None Known
 Easy Bruising Gums Bleed Easily Enlarged Glands Anemia Bleeding Disorder
 Sickle Cell Anemia Lymphoma

- Musculoskeletal:** None Known
 Joint Pain/Swelling Stiffness Muscle Pain Neck Pain Stiff Neck Back Pain
 Osteoarthritis Rheumatoid Arthritis Bone Spurs Broken Bones Compression Fracture Head Injury
 Back Injury Spinal Trauma Birth Trauma Birth Defects Cancer Muscle Weakness
 Muscular Dystrophy Scheuerman's Disease Scoliosis Lupus Spinal Bifida Spondylolisthesis
 Arthritis Neck Injury Osteoporosis

• I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient Name (Signature)

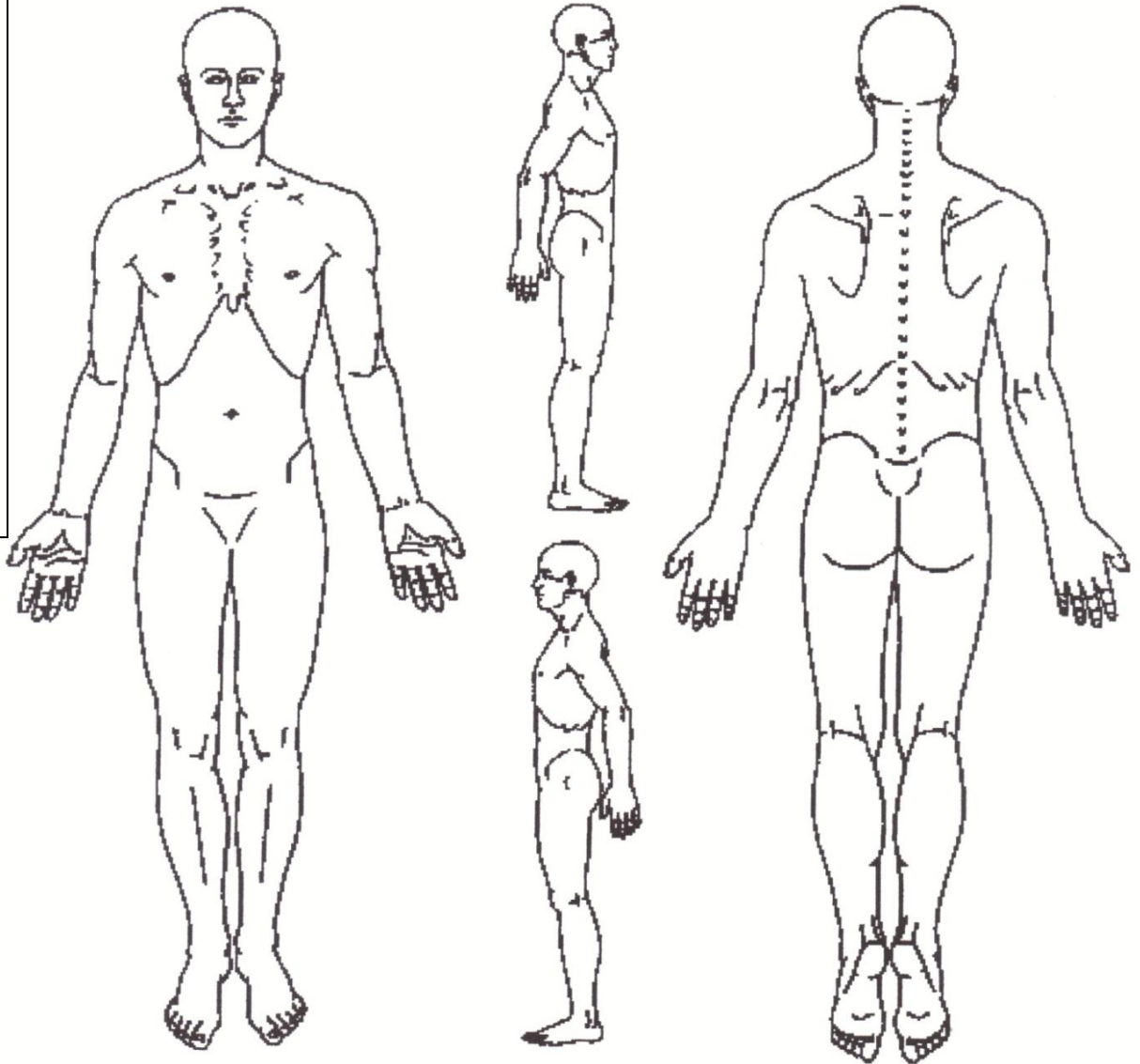
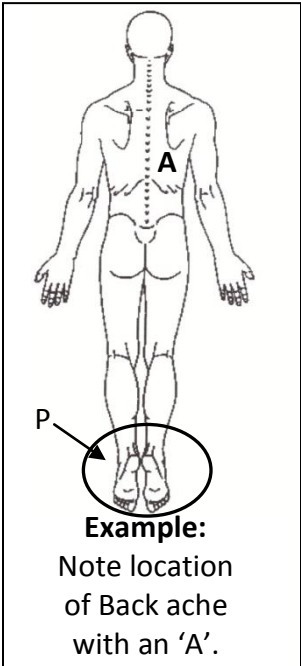
Date

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to your insurance company, your health information on this form may be shared with them. Your health information which your insurance company sees will be kept confidential by them.

Patient Name: _____ DOB: ___/___/___ Date: ___/___/___

How long have you had back pain? _____ Years _____ Months _____ Weeks

On the diagram below, please indicate where you are experiencing pain, **RIGHT NOW**. Use the letters below and mark what sensation you are having in your problem areas. **Mark ALL areas**. For example: If you have a back ache place a 'A' in the area on your back where you are having the ache.



A = ACHE	B = BURNING	N = NUMBNESS	P = PINS AND NEEDLES	S = STABBING	O = OTHER
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DISABILITY QUESTIONNAIRE

Patient Name: _____ **DOB:** ___/___/___ **Date:** ___/___/___

PLEASE READ: This questionnaire is designed to enable us to understand how much your CHIEF COMPLAINT has affected your ability to manage everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **JUST CIRCLE THE ONE CHOICE WHICH CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p>SECTION 1 – Pain Intensity</p> <p>A. The pain comes and goes and is very mild.</p> <p>B. The pain is mild and does not vary much.</p> <p>C. The pain comes and goes and is moderate.</p> <p>D. The pain is moderate and does not vary much.</p> <p>E. The pain is severe but comes and goes.</p> <p>F. The pain is severe and does not vary much.</p>
<p>SECTION 2 – Personal Care</p> <p>A. I would not have to change my way of washing or dressing in order to avoid pain.</p> <p>B. I do not normally change my way of washing or dressing even though it causes some pain.</p> <p>C. Washing and dressing increase the pain, but I manage not to change my way of doing it.</p> <p>D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.</p> <p>E. Because of the pain, I am unable to do any washing and dressing without help.</p>
<p>SECTION 3 – Lifting</p> <p>A. I can lift heavy weights without extra pain</p> <p>B. I can lift heavy weights, but it causes extra pain</p> <p>C. Pain prevents me from lifting heavy weights off the floor.</p> <p>D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.</p> <p>E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</p> <p>F. I can only lift very light weights, at the most.</p>
<p>SECTION 4 – Walking</p> <p>A. Pain does not prevent me from walking any distance.</p> <p>B. Pain prevents me from walking less than one mile.</p> <p>C. Pain prevents me from walking more than one mile.</p> <p>D. Pain prevents me from walking more than ½ mile.</p> <p>E. I can only walk while using a cane or on crutches.</p> <p>F. I am in bed most of the time and have to crawl to the toilet.</p>
<p>SECTION 5 – Sitting</p> <p>A. I can sit in any chair as long as I like without pain.</p> <p>B. I can only sit in my favorite chair as long as I like.</p> <p>C. Pain prevents me from sitting more than one hour.</p> <p>D. Pain prevents me from sitting more than ½ hour.</p> <p>E. Pain prevents me from sitting more than ten minutes.</p> <p>F. Pain prevents me from sitting at all.</p>

<p>SECTION 6 – Standing</p> <p>A. I can stand as long as I want without pain.</p> <p>B. I have some pain while standing, but it does not increase with time.</p> <p>C. I cannot stand for longer than one hour without increasing pain.</p> <p>D. I cannot stand for longer than ½ hour without increasing pain.</p> <p>E. I can't stand for more than 10 minutes without increasing pain.</p> <p>F. I avoid standing because it increases pain right away.</p>
<p>SECTION 7 – Sleeping</p> <p>A. I get no pain in bed.</p> <p>B. I get pain in bed, but it does not prevent me from sleeping.</p> <p>C. Because of pain, my normal night's sleep is reduced by less than one-quarter.</p> <p>D. Because of pain, my normal night's sleep is reduced by less than one-half.</p> <p>E. Because of pain, my normal night's sleep is reduced by less than three-quarters.</p> <p>F. Pain prevents me from sleeping at all.</p>
<p>SECTION 8 – Social Life</p> <p>A. My social life is normal and gives me no pain.</p> <p>B. My social life is normal, but increases the degree of my pain.</p> <p>C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.</p> <p>D. Pain has restricted my social life and I do not go out very often.</p> <p>E. Pain has restricted my social life to my home.</p> <p>F. Pain prevents my social life all together.</p>
<p>SECTION 9 – Traveling</p> <p>A. I get no pain while traveling</p> <p>B. I get some pain while traveling, but none of my usual forms of travel make it any worse.</p> <p>C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.</p> <p>D. I get extra pain while traveling which compels me to seek alternative forms of travel.</p> <p>E. Pain restricts all forms of travel.</p> <p>F. Pain prevents all forms of travel except that done lying down.</p>
<p>SECTION 10 – Changing Degree of Pain</p> <p>A. My pain is rapidly getting better.</p> <p>B. My pain fluctuates, but overall is definitely getting better.</p> <p>C. My pain seems to be getting better, but improvement is slow at present.</p> <p>D. My pain is neither getting better nor worse.</p> <p>E. My pain is gradually worsening.</p> <p>F. My pain is rapidly worsening.</p>

Disability Index Score: _____ %

CONSENT TO CARE

Patient Name: _____ **DOB:** ___/___/___ **Date:** ___/___/___

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

Patient Name (Signature)

Date

X-RAY QUESTIONNAIRE (FOR WOMEN ONLY)

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

There is a possibility that I may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because: _____

Date of last menstrual period: _____

Patient Name (Signature)

Date