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

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 Every day 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: ________________________

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 (Signature) Date

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 ❑Heath Attack ❑Irregular Heart Beat ❑Pressure Over the Chest ❑Pain Down the Left Arm
❑High Triglycerides ❑High Cholesterol ❑Perfuse 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 ❑Horsens ❑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/Lymph:❑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**

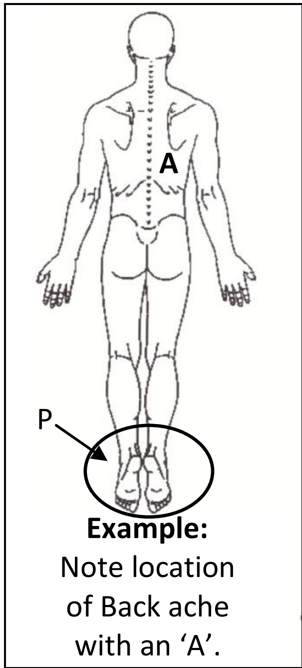
NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to your insurance company, your health information on this form may be shared with them. Your health information which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

REVISED OSWESTRY PAIN QUESTIONNAIRE

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 an 'A' in the area on your back where you are having the ache.



Example:
Note location of Back ache with an 'A'.

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

____

Patient Name (Signature) **Date**

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.** If a question does not apply to why you are being seen please write 'Does not apply' in the box.

SECTION 1 – Pain Intensity
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 – Lifting
A. I can lift heavy weights without extra pain
B. I can lift heavy weights, but it causes extra pain
C. Pain prevents me from lifting heavy weights off the floor.
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.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 – Walking
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking less than one mile.
C. Pain prevents me from walking more than one mile.
D. Pain prevents me from walking more than ½ mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

Disability Index Score: _______ %

SECTION 6 – Standing
A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing pain.
F. I avoid standing because it increases pain right away.

SECTION 7 – Sleeping
A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life
A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. Pain prevents my social life all together.

SECTION 9 – Traveling
A. I get no pain while traveling
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

Patient Health Questionnaire
(PHQ-9)

Patient Name ____ **Date** _______________

Over the **last two weeks**, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

For office coding _______ + _______ + _______ + _______

Total Score: _______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very Difficult	Extremely difficult
☐	☐	☐	☐

Patient Name (Printed) **Patient Name (Signature)** **Date**

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Fill status notification -** Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions -** Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Advantage Healthcare of Charleston, LLC. as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.

Consent

By signing this consent form you are agreeing that your provider at Advantage Healthcare of Charleston, LLC. may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it. This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Advantage Healthcare of Charleston, LLC. to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name: ____

Patient Signature: ____

Name of Parent or Legal Guardian (if applicable): ____

Signature of Parent or Legal Guardian (if applicable): ____

Date: ___ / ___ / ______

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**