

# Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

## PATIENT INFORMATION

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_@\_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell : \_\_\_\_\_

Social Security #: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Marital Status:  Married  Single  Divorced  Separated  Other \_\_\_\_\_

Name of Spouse or Nearest Relative: \_\_\_\_\_ Phone: \_\_\_\_\_

Your Occupation \_\_\_\_\_ Your Employer: \_\_\_\_\_

Referred to this Office by:  Friend/Family Member - Name? \_\_\_\_\_

Yellow Pages  Mail  Clinic Location  Other \_\_\_\_\_

Payment for Services will be by:  Cash  Check  Credit Card  Health Insurance

Automobile Insurance  Worker's Compensation

Name of Insurance Co.: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Are you covered by more than one insurance company?  Yes  No Name \_\_\_\_\_

## MEDICAL/FAMILY HISTORY      **S = Self   M = Mother   F = Father**

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F	S	M	F	S	M	F																					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	venereal disease

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

Have you been treated by a chiropractor before? \_\_\_\_\_yes \_\_\_\_\_no

If so, has it been in the last 6 months? \_\_\_\_\_yes \_\_\_\_\_no

Describe Condition \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_

### SURGICAL HISTORY:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Have you ever had a metal implant?  Yes  No

Ever been gunshot?  Yes  No

ACCIDENT HISTORY  Job  Auto  Other 1. \_\_\_\_\_ Date: \_\_\_\_\_

Job  Auto  Other 2. \_\_\_\_\_ Date: \_\_\_\_\_

(over please)

**PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:**

Please Rate Your symptoms(1-10, with 1 being least serious)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_

SYMPTOMS ARE WORSE IN MORNING AFTERNOON NIGHT

WHEN AND HOW OCCURRED? \_\_\_\_\_

SYMPTOMS DEVELOPED FROM: JOB RELATED INJURY AUTO ACCIDENT OTHER  
ACCIDENT ILLNESS UNKNOWN CAUSE GRADUAL ONSET DATE OCCURRED: \_\_\_\_\_  
 SYMPTOMS HAVE PERSISTED FOR # \_\_\_\_HOUR(S) \_\_\_\_DAY(S) \_\_WEEK(S) \_\_MONTH(S) \_\_YEAR(S)  
 SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT  
 HAVE YOU EVER HAD THIS BEFORE: NO YES WHEN? \_\_\_\_\_  
 IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):  
\_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATIONS NO YES WHAT KIND? \_\_\_\_\_  
 ARE YOU TAKING ANY MEDICATIONS NO YES WHAT KIND? \_\_\_\_\_  
 ARE YOU PREGNANT NO YES DATE OF LAST MENSTRUAL PERIOD \_\_\_\_\_

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:**  
BENDING REACHING STRAINING AT STOOL COUGHING SITTING TURNING HEAD  
LIFTING SNEEZING WALKING LYING DOWN STANDING

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:**  
BENDING SITTING LIFTING STANDING LYING DOWN TURNING HEAD REACHING  
WALKING

**PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:**  
blurred vision buzzing in ears cold feet cold hands cold sweats concentration loss/confusion  
constipation depression/weeping spells diarrhea dizziness face flushed fainting fatigue fever  
head seems too heavy headaches insomnia light bothers eyes loss of balance loss of smell loss of taste  
low resistance to colds muscle jerking numbness in fingers numbness in toes pins and needles in arms  
pins and needles in legs ringing in ears shortness of breath stiff neck stomach upset

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

Preston L. Peacock DC DABCO – Advanced Chiropractic Center

DATE OF VISIT \_\_\_/\_\_\_/20\_\_\_ Patient \_\_\_\_\_ DOB \_\_\_\_\_

Check **ONE**: \_\_\_ INITIAL EXAMINATION \_\_\_ RE-EVALUATION \_\_\_ NEW CONDITION

FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms \_\_\_\_\_

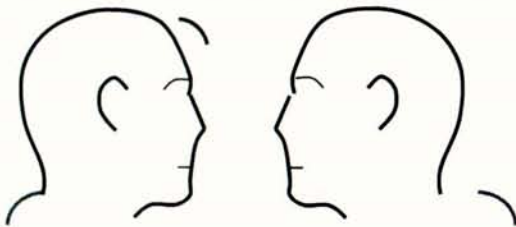
FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint?  
\_\_\_\_\_

**SUBJECTIVE PAIN ASSESSMENT**

**RATE YOUR PAIN**

**Right**

**Left**

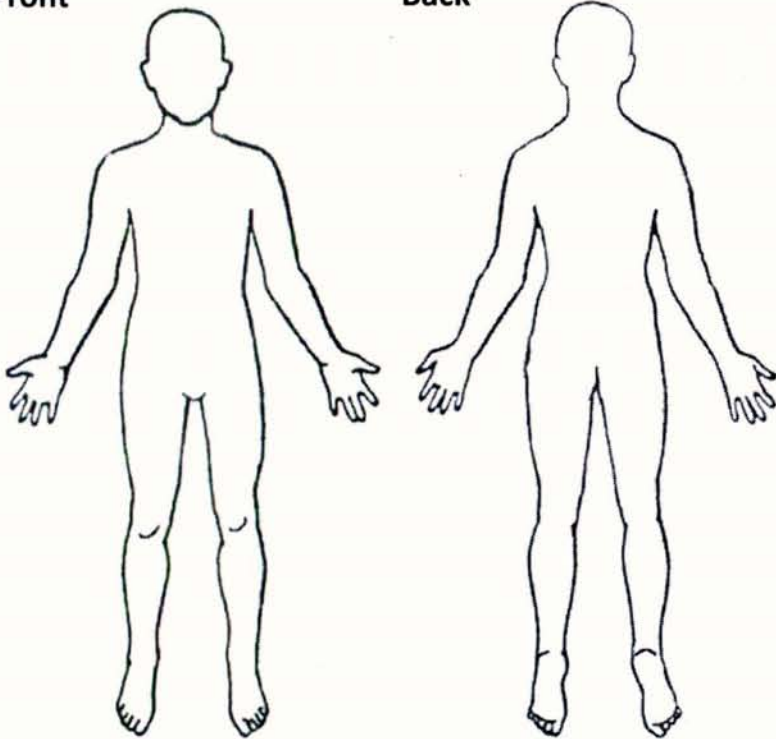


Place an "X" on the drawings where you have pain and indicate the type of pain you are experiencing:

- A=ACHE      B=BURNING      ST=STABBING
- SP=SPASM    N=NUMBNESS    P=PINS AND NEEDLES
- T= THROBBING

**Front**

**Back**



Additional Notes:

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**PAIN SCALE:** Please circle the number that best describes your overall pain:

0      1      2      3      4      5      6      7      8      9      10      10+

NONE

LITTLE

MEDIUM

SEVERE

EXCRUCIATING

**PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE**

**DATE**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Neck Disability Index

*This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.*

### Pain Intensity

- I have no pain at the moment. (0)
- The pain is very mild at the moment. (1)
- The pain is moderate at the moment. (2)
- The pain is fairly severe at the moment. (3)
- The pain is very severe at the moment. (4)
- The pain is the worst imaginable at the moment. (5)

### Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain. (0)
- I can look after myself normally but it causes extra pain. (1)
- It is painful to look after myself and I am slow and careful. (2)
- I need some help but manage most of my personal care. (3)
- I need help every day in most aspects of self care. (4)
- I do not get dressed, I wash with difficulty and stay in bed. (5)

### Lifting

- I can lift heavy weights without extra pain. (0)
- I can lift heavy weights but it gives extra pain. (1)
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- I can lift very light weights. (4)
- I cannot lift or carry anything at all. (5)

### Reading

- I can read as much as I want to with no pain in my neck. (0)
- I can read as much as I want to with slight pain in my neck. (1)
- I can read as much as I want with moderate pain in my neck. (2)
- I cannot read as much as I want because of moderate pain in my neck. (3)
- I can hardly read at all because of severe pain in my neck. (4)
- I cannot read at all. (5)

### Headaches

- I have no headaches at all. (0)
- I have slight headaches that come infrequently. (1)
- I have moderate headaches which come infrequently. (2)
- I have moderate headaches which come frequently. (3)
- I have severe headaches which come frequently. (4)
- I have headaches almost all the time. (5)

### Concentration

- I can concentrate fully when I want to with no difficulty. (0)
- I can concentrate fully when I want to with slight difficulty. (1)
- I have a fair degree of difficulty in concentrating when I want to. (2)
- I have a lot of difficulty in concentrating when I want to. (3)
- I have a great deal of difficulty in concentrating when I want to. (4)
- I cannot concentrate at all. (5)

### Work

- I can do as much work as I want to. (0)
- I can do my usual work, but no more. (1)
- I can do most of my usual work, but no more. (2)
- I cannot do my usual work. (3)
- I can hardly do any work at all. (4)
- I cannot do any work at all. (5)

### Driving

- I can drive my car without any neck pain. (0)
- I can drive my car as long as I want with slight pain in my neck. (1)
- I can drive my car as long as I want with moderate pain in my neck. (2)
- I cannot drive my car as long as I want because of moderate pain in my neck. (3)
- I can hardly drive at all because of severe pain in my neck. (4)
- I cannot drive my car at all. (5)

### Sleeping

- I have no trouble sleeping. (0)
- My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- My sleep is mildly disturbed (1-2 hours sleepless). (2)
- My sleep is moderately disturbed (2-3 hours sleepless). (3)
- My sleep is greatly disturbed (3-5 hours sleepless). (4)
- My sleep is completely disturbed (5-7 hours sleepless). (5)

### Recreation

- I am able to engage in all my recreation activities with no neck pain at all. (0)
- I am able to engage in all my recreation activities, with some pain in my neck. (1)
- I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- I can hardly do any recreation activities because of pain in my neck. (4)
- I cannot do any recreation activities at all. (5)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Oswestry Low Back Disability Index

### Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

### Personal Care (washing, dressing, etc.)

- I can look after myself normally but it is very painful.
- I can look after myself normally but it is very painful.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty, and stay in bed.

### Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

### Walking

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than 1 mile.
- Pain prevents me walking more than ¼ of a mile.
- Pain prevents me walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

### Sitting

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

### Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than ½ an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

### Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than ½ an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

### Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain, I have less than 6 hours sleep.
- Because of pain, I have less than 4 hours sleep.
- Because of pain, I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

### Social Life

- My social life is normal and cause me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

### Traveling

- I can travel anywhere without pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys of over two hours.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to receive treatment.

### Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is rapidly worsening.

**ACCIDENT/INJURY FORM**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time: \_\_\_am \_\_\_pm Location of Accident \_\_\_\_\_

**AUTO INJURY**

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Did your car strike the others involved: ( ) Yes ( ) No ( ) Undetermined

Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined

As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No

**ON-THE-JOB INJURY**

How did the injury occur? \_\_\_\_\_

Did you report the injury to your foreman or employer: ( ) Yes ( ) No

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

**OTHER**

Describe the circumstances of the accident (Be Specific) \_\_\_\_\_

\*\*\*\*\*

**CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT**

- |                  |                            |                        |                   |
|------------------|----------------------------|------------------------|-------------------|
| ( ) Headache     | ( ) Sleeping Problems      | ( ) Lights Bother Eyes | ( ) Diarrhea      |
| ( ) Neck Pain    | ( ) Head Too Heavy         | ( ) Loss of Memory     | ( ) Feet Cold     |
| ( ) Neck Stiff   | ( ) Pins & Needles in Arms | ( ) Ears Ringing       | ( ) Hands Cold    |
| ( ) Dizziness    | ( ) Pins & Needles in Legs | ( ) Face Flushed       | ( ) Stomach Upset |
| ( ) Back Pain    | ( ) Numbness in Fingers    | ( ) Buzzing in Ears    | ( ) Constipation  |
| ( ) Nervousness  | ( ) Numbness in Toes       | ( ) Loss of Balance    | ( ) Cold Sweats   |
| ( ) Tension      | ( ) Shortness of Breath    | ( ) Fainting           | ( ) Fever         |
| ( ) Irritability | ( ) Fatigue                | ( ) Loss of Smell      | ( ) Other         |
| ( ) Chest Pain   | ( ) Depression             | ( ) Loss of Taste      |                   |

Did you require post-accident hospitalization? ( ) Yes ( ) No

Have you lost any days of work? ( ) Yes ( ) No If Yes, \_\_\_\_\_ through \_\_\_\_\_

**INSURANCE INFORMATION**

Your Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

Other Party's Name \_\_\_\_\_ Address \_\_\_\_\_

Other Party's Ins. Co. \_\_\_\_\_ Address \_\_\_\_\_

Have you been contacted by an insurance adjustor regarding this claim ( ) Yes ( ) No

If yes, name of adjustor \_\_\_\_\_ Company \_\_\_\_\_

Do you have an attorney that has advised you in this case: ( ) Yes ( ) No

If yes, attorney's name \_\_\_\_\_ Address \_\_\_\_\_

Signature \_\_\_\_\_



Preston Peacock DC

408 HWY 80 SW

Pooler GA, 31322

Phone 912-748-0350

Fax 912-450-0350

Email:AdvancedChiro@hargray.com

**PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION  
TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

Advanced Chiropractic Center has the right to use and/or disclose information about me (or someone else for whom I have the authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and health care operations. I understand they will not release any record without written authorization by me or persons elected.

The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy without charge by asking for it.

I have the right to request restriction on how my information is used and/or disclosed in order to execute treatment, payment or healthcare operations. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re-disclosure by the recipient.

The Practice may communicate confidential information to me, including invoices for services, e-mail, and call for appointment times or missed appointments, birthday cards and Holiday cards.

I also realize that I may be overheard or may hear other patients talking while in the therapy bay.

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Authorizing Patient Name and Signature

Date



**Preston Peacock DC DABCO**

408 SW Highway 80

Pooler GA, 31322

Phone 912-748-0350

Fax 912-450-0350

Email: [AdvancedChiro@hargray.com](mailto:AdvancedChiro@hargray.com)

## Informed Consent

Advanced Chiropractic Center  
Dr. Preston L. Peacock  
408 HWY 80 SW  
Pooler, GA 31322  
(912) 748- 0350 Fax(912) 450-0350

Patient Name: \_\_\_\_\_

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. The procedure is referred to as "spinal manipulation" or "spinal adjustment". As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains, and dislocations., Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-rays equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature or Signature of Guardian or Parent

# AMERICAN RADIOLOGICAL SERVICES

(419) 269-2140

(800) 442-1202

PATIENT \_\_\_\_\_ CLINIC \_\_\_\_\_ FILM DATE \_\_\_\_\_  
AGE \_\_\_\_\_ SEX M  F  SOCIAL SECURITY # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
PATIENT ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

## X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to American Radiological Services (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

### **PATIENT HISTORY**

PATIENT PRESENTATION \_\_\_\_\_

TRAUMA? YES  NO  EXPLAIN \_\_\_\_\_

PAST MEDICAL HISTORY \_\_\_\_\_

MALIGNANCY? YES  NO  DETAILS \_\_\_\_\_

DIAGNOSIS/CONCERNS/QUESTIONS [NO ICD CODES PLEASE] \_\_\_\_\_

PLEASE COMPLETE INSURANCE/BILLING INFO ON REVERSE SIDE

**Advanced Chiropractic Center PC  
Preston Peacock DC DABCO**

408 SW Hwy 80  
Pooler GA, 31322

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Phone 912-748-0350  
Fax 912-450-0350  
Email [Advancedchiro@hargray.com](mailto:Advancedchiro@hargray.com)

LETTER OF PROTECTION

PATIENT NAME: \_\_\_\_\_

ATTORNEY NAME: \_\_\_\_\_

ACCIDENT DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

We, the undersigned patient and attorney, will protect the interest of Dr. Preston L. Peacock DC DABCO / Advanced Chiropractic Center ("practice") out of the proceeds from any settlement, judgment or verdict, relating to the accident listed above.

By "interest" we mean any outstanding balance owed to the practice for treatment rendered to me, the patient, for injuries sustained on the above date.

This letter of protection shall not be modified or revoked without written consent of Dr. Preston L. Peacock DC DABCO / Advanced Chiropractic Center.

\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Patient's Signature

\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Attorney's Signature



**Preston Peacock DC DABCO**

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**CREDIT GUARANTEE  
AUTO INSURANCE ASSIGNMENT  
PERSONAL BALANCES**

**INSURANCE ASSIGNMENT**

Our Auto Insurance Assignment Program is designed to render you immediate care and keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your insurance carrier on your behalf and wait up to 6 months for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you provide a credit card to guarantee payment of your bill and that you provide us with the following:

**Your complete automobile insurance information**

**Your family health insurance plan information**

**FILING PROCEDURE**

We will periodically submit claims on your behalf to both your automobile and health insurance carriers.

Any overpayments resulting in credit balances will be refunded promptly at the conclusion of your care.

Balances not paid within 6 months after conclusion of your care will be charged to your designated credit card below. You will be sent a payment voucher. Should settlement be reached prior to the 6 month grace period or should care be terminated for any reason prior to your physician dismissal all balances become due immediately, will be charged to your credit card and are subject to monthly interest charges.

CREDIT CARD:     AMEX     VISA     MC     DISCOVER

CARDHOLDER NAME \_\_\_\_\_

CARD # \_\_\_\_\_ EXP. DATE \_\_\_\_\_

I agree to the above terms and authorize you to bill the charge card. I understand that should payment not be received within 6 months after termination of my care or should I terminate care before being dismissed by your physician, I will be charged the amount outstanding on my account.

Signature \_\_\_\_\_ Date \_\_\_\_\_