Patient History Update

Please complete this questionnaire. This confidential history will be part of your permanent records.
THANK YOU.

Name_____ Date_____

To ensure our records are correct, please fill in the information below:

Address_____ City_____ State_____ Zip_____

Home Phone #_____ Cell Phone #_____

Work Phone#_____

Email Address:_____

Please describe in your own words any pain or symptoms you are experiencing:

How long have you had this condition?

Have you had this or similar pain/ symptoms in the past?

Do any positions make it feel worse?

Do any positions make it feel better?

Is this condition interfering with your:☐ Work ☐ Sleep ☐ Daily Routine☐ Other:_____

Other doctors or therapists who have treated THIS condition:

What do you think caused this condition?

Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Myrtle Beach Spine Center, PA

100 Legends Drive, Suite A, Myrtle Beach, SC 29579
(843) 236.9090 • Fax (843) 236.9099
www.myrtlebeachspinecenter.com

Patient Medication List

Prescription / Doseage:

_____

_____

_____

_____

_____

Medication Allergies:

_____

_____

_____

_____

_____

Over the Counter Medicine (Tylenol ect.) / Doseage:

_____

_____

_____

_____

_____

_____

Name_____ **Date**_____

FAMILY HEALTH HISTORY

***please fill out as completely as possible and be specific where indicated*

***also indiciate if they are living (L) or deceased (D)*

Condition	self	mother/father	sibling(s)	children	aunt/uncle	grandparent(s) (both sides)
alcoholism						
alzheimers						
allergies						
anemia						
arthritis (type)						
asthma						
back pain						
bleeding disorder						
cancer (type)						
carpal tunnel						
depression						
diabetes (type)						
epilepsy						
fatigue						
heart disease (type)						
high blood pressure						
kidney disease (type)						
lupus						
migraines						
multiple sclerosis						
neck pain						
obesity						
osteoporosis						
parkinson's disease						
scoliosis						
stroke						
thryoid disorder						

Name: _____ Date: _____

CHECKLIST: Review of Systems

PLEASE CIRCLE ALL THAT APPLY

General-
Weight loss or gain
Fatigue
Fever or chills
Weakness
Trouble sleeping

Skin-
Rashes
Lumps
Itching
Dryness
Color changes
Hair and nail changes

Head-
Headache
Head injury

Ears-
Decreased hearing
Ringing in ears (tinnitus)
Earache
Drainage

Eyes-
Vision
Glasses or contacts
Pain
Redness
Blurry or double vision
Flashing lights
Specks
Glaucoma
Cataracts
Last eye exam

Nose-
Stuffiness
Discharge
itching
Hay fever
Nosebleeds
Sinus pain

Throat
Teeth
Gums
Bleeding
Dentures
Sore tongue
Dry mouth
Sore throat
Hoarseness
Thrush
Non-healing sores
Last dental exam
_____

Neck-
Lumps
Swollen glands
Pain
Stiffness

Breasts
Lumps
Pain
Discharge
Self-exams
Breast-feeding

Respiratory-
Cough (dry or wet, productive)
Sputum (color and amount)
Coughing up blood (hemoptysis)
Shortness of breath (dyspnea)
Wheezing
Painful breathing

NAME: _____ DATE: _____

Cardiovascular-
Chest pain or discomfort
Tightness
Palpitations
Shortness of breath with activity (dyspnea)

Difficulty breathing lying down (orthopnea)
Swelling (edema)

Sudden awakening from sleep with shortness of breath (Paroxysmal Nocturnal Dyspnea)

Gastrointestinal-
Swallowing difficulties
Heartburn
Change in appetite
Nausea

Change in bowel habits
Rectal bleeding
Constipation
Diarrhea

Yellow eyes or skin (jaundice)

Urinary-
Frequency
Urgency
Burning or pain

Blood in urine (hematuria)
Incontinence

Change in urinary strength

Genital-
Male-
Pain with sex
Hernia
Penile discharge

Sores
Masses or pain
Erectile dysfunction

STD's

Female-
Pain with sex
Vaginal dryness

Hot flashes
Vaginal discharge

Itching or rash
STD's
_____

Vascular-
Calf pain with walking (Claudication)

Leg cramping

Musculoskeletal-
Muscle or joint pain
Stiffness

Back pain
Redness of joints

Swelling of joints
trauma

Neurologic-
Dizziness
Fainting
Seizures

Weakness
Numbness
Tingling

Tremor _____

Hematologic-
Ease of bruising

Ease of bleeding

Endocrine-
Head or cold intolerance
Sweating

Frequent urination (polyuria)
Thirst (polydypsia)

Change in appetite (polyphagia)

Psychiatric-
Nervousness
Depression

Memory loss

NAME: _____ DATE: _____

Myrtle Beach Spine Center, PA -- Office Policies

- We advise that you follow treatment recommendations given by the doctor,

  Please give 24 hour notice if you are going to miss an appointment

- We reserve the right to charge a $25 fee for any missed appointments.
- Payment is expected at the time of service, unless prior arrangements have been made.

  **Regular monthly payments are expected. A delinquency charge of 1.5 % per month
  - (UP to 18% per year) will be added to any and all delinquent accounts

- If the charges for service are covered by insurance, we will accept assignment of benefits in lieu of cash payments (after co-pays and/or deductibles have been paid by you).
- Finances cannot and will not be discussed over the telephone, if you should have a question you may address it at your next scheduled appointment.
- There are multiple providers in the office.
- Additional letters or forms requested by the patient will be subject to a $35 administration fee. Copies of records will be assessed at a fee of: Pages 1-30 $.65 per page; Pages 31+ $.50 per page + $15 handling fee + Actual Postage Fee (if mailing)

- If there are any questions regarding treatment, treatment recommendation, or insurance please feel free to contact our office immediately to set up a consultation.

Congratulations on choosing to improve your health!!!!

_____
(initials)

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries irritation of a disc condition, and rarely fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke. Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations, or studies are needed. In addition: they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Patient Name (printed) _____

Myrtle Beach Spine Center, PA
100 Legends Drive, Suite A
Myrtle Beach, South Carolina 29579
PH: 843-236-9090

Consent to use PHI

Acknowledgment 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 Myrtle Beach Spine Center, PA 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. I have received a copy of the Notice of Patient Privacy Policy.

_____Patient Initials

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.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

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