

## RE-ACTIVATION OF CARE

According to our records, the date of your last visit was on: \_\_\_\_\_

Please let us know if any of your contact information has changed:

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

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

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

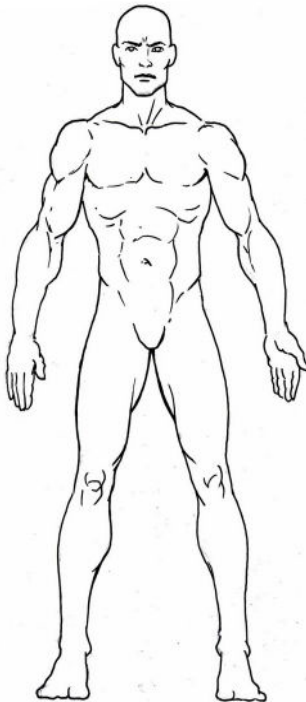
Email Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I prefer to be contacted by:  Home ☎  Mobile ☎  Work ☎

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

Reason for today's visit: \_\_\_\_\_

Please mark the areas of your complaint on the illustration below. Use the following letters to indicate the area and symptoms: P= Pain N= Numbness T= Tenderness S= Spasm



Check if you have symptoms or pain in the following areas:

- Headaches
- Neck
- Shoulder
- Arm  Elbow
- Wrist  Hand
- Upper Back
- Lower Back
- Hip  Leg
- Knee  Ankle
- Foot

Mark the words that describe your pain:

- Dull  Ache  Sharp  Shooting  Stabbing  Burning  Numb

How long have you had this condition? \_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ days

Have you had this condition in the past? \_\_\_\_\_

Is this condition interfering with your work sleep daily routine

other: Please describe: \_\_\_\_\_

Since your last visit, have you had any:

Injuries (Falls, Accidents)

Activities (Pain Caused by too much Gardening)

Conditions (New Medications, New Diagnosis, New Health Problems)

Please describe: \_\_\_\_\_

Have you have any: Surgeries Chiropractic Care Medical Care Physical Therapy

Please list name of provider and condition: \_\_\_\_\_

For Women Only: To your knowledge, are you pregnant? Yes No

Medication List: Please list Dosage:

Prescriptions	Over the Counter (Tylenol)

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\* You May Refuse to Sign This Acknowledgement\***

I, \_\_\_\_\_, have received and had the opportunity to review a copy of Goldsboro Spine Center's Notice of Privacy Practices. I understand that the Notice describes the uses and disclosures of my protected health information and informs me of my rights with respect to my protected health information.

### For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

Signature: \_\_\_\_\_

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

## REVIEW OF SYSTEMS

For established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, PLEASE CIRCLE THE ONES THAT APPLY, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

**Const. (Health in General)**  No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: \_\_\_\_\_

**Ears, Nose, Mouth & Throat**  No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: \_\_\_\_\_

**C-V (Heart & Blood Vessels)**  No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: \_\_\_\_\_

**Resp. (Lungs & Breathing)**  No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: \_\_\_\_\_

**GI (Stomach & Intestines)**  No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: \_\_\_\_\_

**GU (Kidney & Bladder)**  No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: \_\_\_\_\_

**MS (Muscles, Bones, Joints)**  No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: \_\_\_\_\_

**Integ. (Skin, Hair & Breast)**  No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: \_\_\_\_\_

**Neurologic (Brain & Nerves)**  No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: \_\_\_\_\_

**Psychiatric (Mood & Thinking)**  No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: \_\_\_\_\_

**Endocrinologic (Glands)**  No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: \_\_\_\_\_

**Hematologic (Blood/Lymph)**  No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: \_\_\_\_\_

**Allergic/Immunologic**  No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: \_\_\_\_\_

Signature: \_\_\_\_\_

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

Chiropractic Authorization, Release, & Explanation  
Goldsboro Spine Center  
605 N Spence Ave  
Goldsboro, NC 27534  
(919)751-0555

Medical Notes and X-Ray Release

I hereby acknowledge the release of medical information, S.O.A.P notes, and x-ray reports, to Goldsboro Spine Center, Dr. Wayne P. Wagner, and treatment of my condition.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date