WELCOME!

We are delighted to welcome you to Carlton Care Chiropractic. Your health is our utmost priority. Dr. Carlton, with her 25+ years in chiropractic, and our staff, are dedicated to your wellness journey.

Your first visit includes a consult, examination, and assessments. Treatment will begin on your first visit, if Dr. Carlton determines she can help you. (She will facilitate any referrals as need indicates.)

Chiropractic care is a partnership – your active involvement amplifies the effectiveness of your treatment. The more engaged you are, the better your results. Trust the process ..... Dr. Carlton will guide you to feeling better and attaining greater health.

Again, Welcome! ~ We are glad you are here!

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APPLICATION FOR CARE AT CARLTON CARE CHIROPRACTIC

Today's Date:_____ **Patient #:**_____

PATIENT DEMOGRAPHICS

Name:_____ Birthdate:____/_____/_____ Age:_____ ☐ Male ☐ Female

Address:_____ City:_____ State:_____ Zip:_____

Best Phone Contact Number:_____ Email Address:_____

Marital Status: ☐ Single ☐ Married Are You Using Insurance? ☐ Yes ☐ No **NOTE: BE SURE TO READ THE FINANCIAL POLICY CAREFULLY!**

Employer:_____ Occupation:_____

Spouse's Name:_____ Spouse's Employer:_____

Names of Children and Ages:_____

Name of Emergency Contact:_____ Number:_____ Relationship:_____

HISTORY OF COMPLAINT

Please list the condition(s) that brought you to this office: Primary:_____

Secondary:_____ Third:_____ Fourth:_____

On a Scale of **0** to **10** with **10** being the worst pain and **0** being no pain, rate your above complaints by circling the number:

Primary or Chief Complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second Complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third Complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth Complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

TO HELP THE DOCTOR BETTER UNDERSTAND YOUR SYMPTOMS, PLEASE PROVIDE THE FOLLOWING INFORMATION:

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM

What made your symptom(s) start initially? _____ ☐ Did this start suddenly? ☐ Or gradual onset?

Is your problem the result of **ANY** type of accident or injury? ☐ Yes ☐ No

Is this problem caused by or at your workplace? ☐ Yes ☐ No (**NOTE:** Your health insurance does NOT cover WORKPLACE injuries)

Briefly describe ANY injuries or trauma to your body: _____

Is the problem: ☐ Constant ☐ On and Off during the day ☐ It Comes and Goes throughout the week

What relieves symptoms? _____ Makes it worse?_____

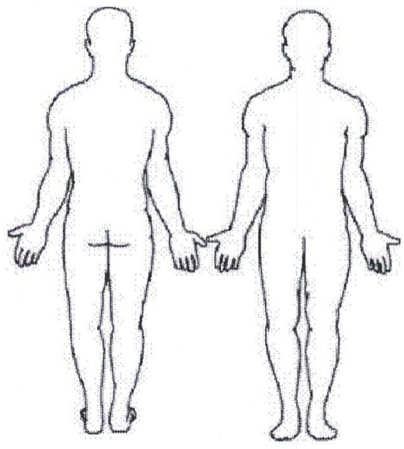
CIRCLE PAIN TYPES EXPERIENCED: Radiating Burning Dull Aching Numbness/ Tingling Sore Sharp/Stabbing

Have you ever been treated for this anywhere else? ☐ No ☐ Yes

Have you ever been to a Chiropractor? ☐ No ☐ Yes

How long ago was your most recent Chiropractic visit? _____

***********MARK SYMPTOM AREAS ON THE BODY DIAGRAM*---------->>**



DOCTOR'S NOTES ONLY BELOW:_____

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QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain 0 1 (2) 3 4 (5) 6 7 (8) 9 10 **worst possible pain**

---

1 – What is your pain RIGHT NOW?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

2 – What is your TYPICAL or AVERAGE pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

OTHER COMMENTS:

_____

_____

_____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

PATIENT'S NAME:_____ HR#:_____ DATE: _____

PAST HISTORY

Have you ever been diagnosed with any of these conditions?

__ Cancer __ Stroke __ Diabetes __ Heart Attack __ Broken Bones/Fracture __ Arthritis (any type) __ Disability __ Other Serious Condition

PLEASE IDENTIFY ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	DESCRIBE BRIEFLY
INJURIES/TRAUMA		
SURGERIES		
HEALTH ISSUES		

REVIEW OF SYSTEMS

******* **PLEASE MARK:** **P** for the **Past** **C** for **Currently** have **N** for **Never** *******

___ Headache
___ Neck Pain
___ Jaw Pain/TMJ
___ Shoulder Pain
___ Upper Back Pain
___ Mid Back Pain
___ Low Back Pain
___ Hip Pain
___ Back Curvature
___ Scoliosis
___ Numb/Tingling Arms, Hands, Fingers
___ Numb/Tingling Legs, Feet, Toes

___ Pregnant
___ Frequent Colds/Flu
___ Convulsions/Epilepsy
___ Tremors
___ Chest Pain
___ Pain with Cough/Sneeze
___ Foot or Knee Pain
___ Sinus/Drainage Problem
___ Swollen/Painful Joints
___ Skin Problems

___ Dizziness
___ Loss of Balance
___ Fainting
___ Double Vision
___ Blurred Vision
___ Ringing in the Ears
___ Hearing Loss
___ Depression
___ Irritable
___ Mood Changes
___ ADD/ADHD
___ Allergies

___ Prostate Problems
___ Impotence/Sexual Dysfunction
___ Digestive Problems
___ Colon Trouble
___ Diarrhea/Constipation
___ Menopausal Problems
___ Menstrual Problems
___ PMS
___ Bed Wetting
___ Learning Disability
___ Eating Disorder
___ Trouble Sleeping

___ Ulcers
___ Heartburn
___ Heart Problems
___ High Blood Pressure
___ Low Blood Pressure
___ Asthma
___ Difficulty Breathing
___ Lung Problems
___ Kidney Trouble
___ Gall Bladder Trouble
___ Liver Trouble
___ Hepatitis (A/B/C)

FAMILY HISTORY

List any conditions that run in your family that may affect this problem: _____

Do you have any other conditions that the doctor should be aware of? ☐ Yes ☐ No List:_____

SOCIAL HISTORY

Smoking? ☐ Yes ☐ No ☐ Quit – Year_____

Recreational Drug Use? ☐ Yes ☐ No

_____ DATE: _____/_____/_____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE MON/DAY/YEAR

_____ DATE: _____/_____/_____

DOCTOR'S SIGNATURE MON/DAY/YEAR

(Continued on Next Page)

PATIENT'S NAME:_____ HR#:_____ DATE: _____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Taking out garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other:_____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

SUPPLEMENTS AND MEDICATIONS

List prescription medications you take: _____

_____

List over the counter (OTC) medications you take: _____

What supplements do you take consistently? _____

_____

_____

Where do you purchase your supplements? _____

Describe what you do to move your body (exercise/stretch): _____

_____

Describe your current health and energy: (circle one) Poor Fair Good Vibrant

_____ DATE: _____/_____/_____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE MON/DAY/YEAR

_____ DATE: _____/_____/_____

DOCTOR'S SIGNATURE MON/DAY/YEAR

PATIENT'S NAME:_____ HR#:_____ DATE: _____

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures

Chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments. With consideration, I do hereby consent to treatment by any means, method, and/or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____
Patient Name (Please print)

_____ _____/_____/_____ 
Patient or Authorized Person's Signature **Date** **Witness Initials**

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions otherwise see our front desk staff for further explanation.*

□ The first date of my last menstrual cycle was on _____/_____/_____ (Date)

□ To the best of my knowledge, I am not pregnant.

By my signature below, I acknowledge that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____
Patient Name (Please print)

_____ _____/_____/_____ 
Patient or Authorized Person's Signature **Date** **Witness Initials**

CARLTON CARE CHIROPRACTIC

Notice of Privacy Practices

NOTICE REGARDING YOUR RIGHT TO PRIVACY

Please complete the following where indicated and return to Front Desk Staff.

I hereby acknowledge I have been offered a copy of Carlton Cares Chiropractic Privacy Practices Notice.

I understand my rights as well as the Practice's duty to protect my health information. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature:_____ Date:_____

Please print name:_____ Phone #: (_____)_____

If not signed by the patient, please indicate relationship:

- ☐ Parent or Guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient

Name of Patient:_____

Signed form received by:_____

PATIENT'S NAME:_____ HR#:_____ DATE: _____

FINANCIAL POLICY

WE CAN BILL YOUR INSURANCE FOR SERVICES RENDERED AT THIS OFFICE AS A COURTESY TO YOU. YOU ARE RESPONSIBLE TO HAVE COMPLETE UNDERSTANDING OF YOUR INSURANCE AS IT APPLIES TO CHIROPRACTIC SERVICES AT CARLTON CARE CHIROPRACTIC. IF YOU ARE NOT SURE OF YOUR DEDUCTIBLE, CO-PAYS, OR CO-INSURANCE AS THEY APPLY TO CARE HERE. . . . IT IS YOUR RESPONSIBILITY TO CALL YOUR INSURANCE CARRIER AND INQUIRE. ALTHOUGH WE DO OUR DUE DILIGENCE, WE ARE OFTEN GIVEN INCORRECT OR INCOMPLETE INFORMATION BY THE INSURANCE COMPANIES.

I hereby authorize payments to be made directly to **CARLTON CARE CHIROPRACTIC**, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to **CARLTON CARE CHIROPRACTIC** for any and all services or products I receive at this office.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. _____ Patient Initials.

BILLING YOUR INSURANCE: I hereby authorize CARLTON CARE CHIROPRACTIC to verify my insurance benefits and/or submit my claim to my insurance carrier. I agree to facilitate payment of claims by contacting my insurance carrier when necessary. I agree it is my responsibility to fully understand my coverage including co-pays, deductibles, etc. as well as checking to determine if Dr. Carlton is in network or if I am to pay out of pocket. I agree to notify CARLTON CARE CHIROPRACTIC as soon as possible of any changes related to my insurance coverage. Failing to do so may result in unpaid claims, and I will be responsible for the balance of the claim. CARLTON CARE CHIROPRACTIC does not accept responsibility for incorrect information given by me or my insurance carrier regarding my insurance benefits or benefit plans.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. _____ Patient Initials.

CANCEL/RESCHEDULE: In consideration of others, I agree to notify the CARLTON CARE CHIROPRACTIC office if I need to cancel or reschedule at least ***two hours*** prior to my scheduled appointment. I agree to be charged the amount of $60.00 if I NO SHOW or CANCEL LATE (less than 2 hours in advance). I acknowledge that I may notify CARLTON CARE CHIROPRACTIC via text or phone call to the office.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. _____ Patient Initials.

_____ DATE: _____/_____/_____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE MON/DAY/YEAR

_____ DATE: _____/_____/_____

DOCTOR'S SIGNATURE MON/DAY/YEAR

Carlton Care Chiropractic
Dr. A. Maria Carlton, DC

Patient name:_____

List your doctors: (Please list city & state if not Wauchula)

Chiropractor (s) seen in the last 5 years:

Name: _____
City & state: _____
Name:_____
City & state: _____

Primary care doctor:_____
City & state: _____

Orthopedic doctor:_____
City & state: _____

Pain doctor:_____
City & state: _____

Cardiologist:_____
City & state: _____

Neuro doctor:_____
City & state:_____

Other doctor (s):_____
City & state:_____