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!

(Continued on Next Page)

CARLTON CARE CHIROPRACTIC

ACCIDENT HISTORY

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Initial:_____

Birth Date:____/____/_____ Age:_____ Email Address:_____

Address:_____ City:_____ ST:_____ Zip:_____

Home Phone: (_____)_____ Work or Cell Phone: (_____)_____

Occupation:_____ Employer:_____

Spouse's Name:_____ Business/Employer:_____

Who is your Primary Care Physician? _____Phone Number: (_____)_____

ACCIDENT & INSURANCE INFORMATION

Type of Accident: □ **Automobile** □ **Slip and Fall** **Date of Accident:____/____/_____**

****

AUTOMOBILE ACCIDENT DETAILS

Driver of automobile you were in:_____ Name of their auto insurance:_____

Policy #:_____ Claim #:_____

Auto Insurance phone #: (_____)_____ Name of Insurance Adjuster:_____

Adjuster's phone #: (_____)_____ Adjuster's fax #: (_____)_____

Names of all the people in the vehicle when accident occurred:_____

****

SLIP AND FALL ACCIDENT INFORMATION

Where did the accident occur? □ at a business □ other location type: _____

Address of accident location: _____

Name of Company, Position and/or Person who made initial contact with after accident:_____

Contact Phone #: (_____)_____ Other Contact information: _____

****

Did you go to hospital? □ Yes □ No When? □ Immediately □ ____Hours later □ _____ Days later

Which hospital? _____

How did you get to hospital? _____ How long did you stay in hospital? _____

What did the hospital do for your injuries? (collars, splints, x-rays, medication, etc.)_____

What areas were x-rayed? _____ What was their diagnosis? _____

What did they recommend for follow-up care? _____

Was any other doctor consulted after your accident? □ Yes □ No If yes, please complete the information below.

Dr._____ Specialty: _____ Date first seen:____/____/_____

Type of treatment: _____ Treatment frequency:_____ How long did you treat?_____

Dr._____ Specialty: _____ Date first seen:____/____/_____

Type of treatment: _____ Treatment frequency:_____ How long did you treat?_____

ACCIDENT HISTORY (con't.)

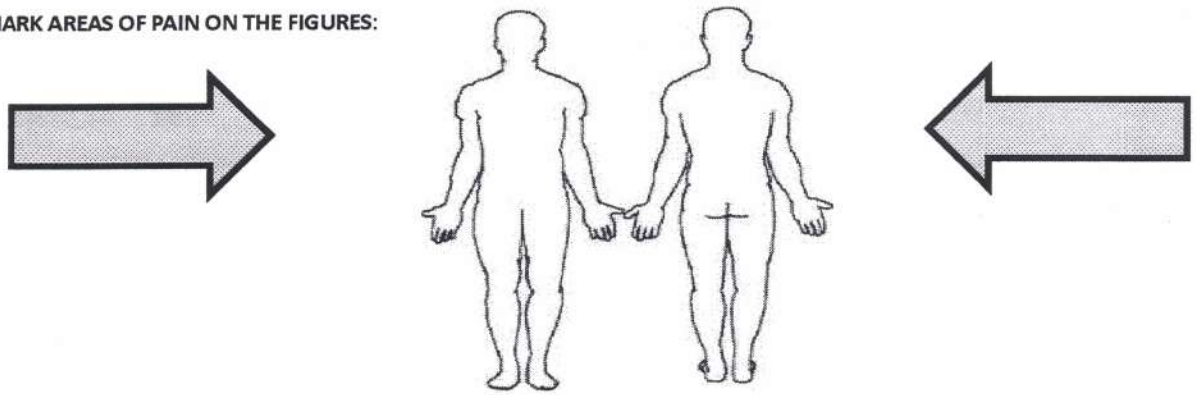
Patient Name: _____

CURRENT COMPLAINTS

Check symptoms you have noticed since the accident:

□ Headaches/Migraines	□ Neck Pain	□ Upper Back Pain	□ Shoulder Pain	□ Midback Pain
□ Low Back Pain	□ Depression	□ Buzzing in Ears	□ Arm/Leg Pain	□ Jaw Pain/Clicking
□ Dizziness	□ Fatigue	□ Loss of Memory	□ Cold Hands/Feet	□ Numbness/Tingling
□ Loss of Smell	□ Irritability	□ Digestive Problems	□ Joint Pain/Stiffness	□ Menstrual Problems
□ Pinched Nerve	□ Loss of Sleep	□ Loss of Balance	□ Chest Pain	□ Light Bothers Eyes
□ Fever	□ Nervousness	□ Vision Problems	□ Urinary Problems	□ Sleeping Problems
□ Paralysis	□ Tension	□ Fainting	□ Pins/Needles Feeling	□ Stomach Upset
□ Difficulty Swallowing	□ Sciatica	□ Sinus Pain	□ Sore Muscles	□ Head Feels too Heavy
□ Other:				

PLEASE MARK AREAS OF PAIN ON THE FIGURES:



OCCUPATIONAL INFORMATION

Job involves: □ Sitting □ Standing How long? _____ □ Lifting □ Bending □ Twisting □ Turning □ Stooping

Physical activity at work: □ Sedentary □ Light manual labor □ Manual labor □ Heavy manual labor

Have you missed any time from work due to the accident? □ Yes □ No If yes, how many days?_____ Dates: _____

Are your work activities restricted as a result of this accident? □ Yes □ No If yes, please explain: _____

Do any of your work activities aggravate your present main complaints? □ Yes □ No If yes, please explain: _____

_____

_____

CURRENT MEDICATIONS

Please list any medications or vitamins you are currently taking:

Medication: _____ What is this for?_____

Medication: _____ What is this for?_____

Medication: _____ What is this for?_____

Medication: _____ What is this for?_____

Medication: _____ What is this for?_____

Medication: _____ What is this for?_____

Medication: _____ What is this for?_____

Medication: _____ What is this for?_____

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

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.

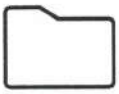
PATIENT'S NAME:_____ HR#:_____ DATE: _____

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)

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

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.*

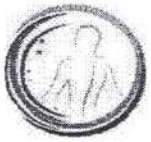
□ The first date of my last menstrual cycle was on _____/_____/_____ (Date)

□ 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)

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



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:_____

ACCIDENT HISTORY (con't.)

Patient Name: _____

X-RAY CONFIRMATION – FEMALES ONLY

At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures.

_____ DATE: _____

PATIENT SIGNATURE

ACKNOWLEDGEMENT OF UNDERSTANDING

I understand the information within this form and guarantee this form was completed correctly and to the best of my knowledge.

_____ DATE: _____

PATIENT SIGNATURE

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize the doctor(s) at Carlton Care Chiropractic and whomever they designate as assistants to administer care to a child.

Name of Child/Minor (please print): _____

Name of Parent/Guardian (please print): _____

Parent/Guardian Signature: _____ DATE: _____

CARLTON CARE CHIROPRACTIC

PLEASE SEND TO:
105 South 9th Ave
Wauchula, FL 33873
FAX: 888-874-7772
QUESTIONS? CALL:
863-473-4732

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD

Patient Name: _____ DOB: _____

I HEREBY AUTHORIZE that my medical records including visit notes, imaging, examination forms and any other information may be disclosed to or by **CARLTON CARE CHIROPRACTIC**.

INFORMATION TO BE DISCLOSED:

- □ General Medical Records
- □ IMAGING DISC(s)
- □ Imaging Reports
- □ Lab Results
- □ Conversations between Providers
- □ Other: _____

EXPIRATION DATE: This authorization will not expire without written revocation.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company and Medicare.

PLEASE SEND TO: Carlton Care Chiropractic, 105 South 9th Avenue, Wauchula, FL 33873
FAX: 888-874-7772 **QUESTIONS? CALL:** 863-473-4732

_____ Date:_____
Patient/Legal Representative Signature

_____
Printed Name of Patient/Legal Representative

Legal Representative's Relationship to Client: _____

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