CARNES CHIROPRACTIC CLINIC

Bob Carnes D.C.

WELCOME

- OUR WELLNESS CENTER PROVIDES HEALTH CARE FOR THE ENTIRE FAMILY
- A MEDICAL HISTORY AND EXAM ARE ROUTINELY DONE TO DETERMINE THE NATURE AND EXTENT OF YOUR PROBLEM
- OTHER SERVICES WHICH ARE OFTEN NEEDED MAY INCLUDE ORTHOPEDIC AND NEUROLOGICAL TEST, LAB TESTS, NUTRITIONAL TESTING, ETC.
- **OUR REGULAR OFFICE HOURS ARE 8:00-5:30, MON – FRI**
- **PLEASE GIVE 24 HOURS NOTICE IF YOU NEED TO CANCEL AN APPOINTMENT.**
- **OUR POLICY IS PAYMENT UPON RECEIPT OF SERVICES.**
- WE ACCEPT CASH, CHECK & CREDIT CARD
- **WE DO NOT FILE INSURANCE**. WE GIVE YOU A RECEIPT WITH THE DIAGNOSIS AND TREATMENT CODES TO USE TO FILE YOUR OWN INSURANCE CLAIMS.
- **MEDICARE PATIENTS** ALSO PAY AT TIME OF SERVICE. WE WILL FILE YOUR MEDICARE CLAIMS. MEDICARE WILL REIMBURSE ANY PAYMENT ALLOWED DIRECTLY TO YOU.
- **WORKER'S COMPENSATION:** WE WILL ACCEPT ASSIGNMENT OF INSURANCE BENEFITS FOR AUTHORIZED WORKER'S COMPENSATION INJURIES. WE MUST HAVE AUTHORIZATION FROM YOUR COMPANY PRIOR TO ACCEPTING ASSIGNMENT.
- **REGULAR FEES:**
  - **FIRST VISIT: $170.00** FOR CONSULTATION, EXAM & TREATMENT
  - **OFFICE VISIT: $57.00** FOR ESTABLISHED PATIENTS
- **SENIOR FEES:** (AGE 62 AND OVER)
  - **FIRST VISIT: $165.00** FOR CONSULTATION, EXAM AND TREATMENT
  - **OFFICE VISIT: $52.00** FOR ESTABLISHED PATIENTS

I HAVE READ THE ABOVE POLICIES AND ACCEPT THEM AS STATED

____ DATE ________________

SIGNATURE

"Protectors of Health" 1 COR. 13:7

2323 W MAIN ST, SUITE 109, DOTHAN, AL 36301 334-794-2225

Revised 08/29/13

CARNES CHIROPRACTIC CLINIC
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PATIENT HISTORY FORM (PLEASE PRINT)

It is very important that you answer all of the questions below so that we may have the information we need to properly serve you. You may put N/A in the blank if the question does not apply to you.

NAME____ __________________________________**DATE**__________________
ADDRESS_______________________________________ CITY/STATE________________________________ ZIP_____________
AGE________ **BIRTHDATE**_____/_____/_____ **GENDER (**Circle One**) Male / Female**
SOCIAL SECURITY NO._________/_______/__________ **PREFERRED LANGUAGE** ___________________________
WORK PHONE (___)_______________ **CELL #** (____)_________________ **HOME PHONE** (_____)___________________
EMAIL ADDRESS____
OCCUPATION_________________________________ **EMPLOYER**______________________________________

Preferred method of communication for patient reminders (Circle one): PHONE or TEXT
If text please CIRCLE phone carrier: VERIZON AT&T OTHER__________
PLEASE NOTE – It is the policy of this office to make reminder call to our patients for appointments so you may receive a reminder text and a reminder call for your appointments.

SPOUSES NAME__________________________________ **OCCUPATION**____
EMPLOYER, ADDRESS & PHONE____

PERSON RESPONSIBLE FOR ACCOUNT____
WHO REFERRED YOU TO OUR OFFICE____

NAME OF PARENT OR GUARDIAN____

HAVE YOU EVER SEEN A CHIROPRACTOR BEFORE________ WHO________________ WHY______________________
____

LISTCURRENT MAJOR PROBLEMS IN ORDER OF IMPORTANCE____
____
____

WHEN DID SYMPTOMS FIRST APPEAR__________________ **ARE SYMPTOMS THE RESULT OF A FALL, LIFTING OR ANY OTHER SPECIFIC INCIDENT**__________ **IF YES, PLEASE EXPLAIN HOW AND WHERE IT HAPPENED** ________________
____

DATE OF INJURY/ILLNESS________________ TIME___________ AM/PM
HAVE YOU EVER HAD THIS CONDITION BEFORE THIS OCCURANCE________ **WHEN**____________________________
________________________________ **WERE YOU HURT ON THE JOB**___________ **AUTO ACCIDENT**________________

WHAT PREVIOUS METHODS HAVE YOU TRIED TO ALLEVIATE YOUR DISCOMFORT_____________________________
____

HAVE YOU CONSULTED ANOTHER DOCTOR FOR THIS PROBLEM (NAME)____

PLEASE LIST ANY TYPE OF SURGERY OR ANY MAJOR DISEASES (HEART, BLOOD PRESSURE ETC)_______________
____

WHAT ARE YOUR HEALTH GOALS? (Circle one) PAIN RELIEF ONLY or PAIN RELIEF and GET HEALTHY/STAY HEALTHY

WOULD YOU LIKE PERSONAL PRAYER FOR YOUR CONDITION? (Circle one) Yes or No

SIGNED____**(PATIENT, PARENT OR GUARDIAN)**

For office use only ***Date***________________

Height: _________ ***Weight:***____________ ***Blood Pressure:***______ /______ ***Heart Rate***_________

Revised 1/27/17 **NOTE** This form is in compliance with Medicare requirements for the government EHR Stage 2 incentive program.
*CMS requires providers to report both race and ethnicity

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Medications that you are <u>CURRENTLY</u> taking. (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)
IF YOU HAVE ADDITIONAL MEDICATIONS PLEASE ATTACH ANOTHER SHEET	

Medications NOT LISTED ABOVE that you have taken recently. (Ex: If you had an infection a month ago and took an antibiotic for it)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

PLEASE LIST ANY VITAMINS THAT YOU ARE NOW OR HAVE BEEN RECENTLY TAKEN ___________________________

____

***Race (CIRCLE one):** American Indian Alaska Native Asian Black or African American
White (Caucasian) Native Hawaiian or Pacific Islander O ther / I Decline to Answer

***Ethnicity (CIRCLE one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

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Family Medical History *(Record one diagnosis in your family history and the affected relative)*

Diagnosis (Write in below)	Father	Mother	Sibling: Circle One brother/sister	Offspring: Circle One Son/daughter
Example: Heart Disease		*X*		

Do you have any MEDICATION ALLEGIES? Y / N If yes, please complete below

Medication Name	Reaction	Onset Date	Additional Comments

Patient Signature: ____ Date:________________

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Metabolic Assessment Form

Name: ______________________ **Age:** ______ **Sex:** _____ **Date:** ____________

Please list the 5 major health concerns in your order of importance:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

Please circle the appropriate number "0 - 3" on all questions below. <u>0 as the least/never</u> to <u>3 as the most/always.</u>

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue of "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3

Category III				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category IV				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category V				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed	Yes	No		

Category VI				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category VII				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category VIII				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

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Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.

Category IX

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X

Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" type headaches	0	1	2	3

Category XIV (Males only)

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males only)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintain morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVI (Menstruating Females Only)

Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 24 days	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Females Only)

How many years have you been menopausal? ____________

Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

How many alcoholic beverages do you consume per week? ________

How many times do you eat out per week? __________

How many times a week do you eat fish? __________

How many caffeinated beverages do you consume per day? _________

How many times a week do you eat raw nuts or seeds? ___________

How many times a week do you workout? ________________

List the three worst foods you eat during the average week: ______________, ______________, ______________

List the three healthiest foods you eat during the average week: ______________, ______________, ______________

Do you smoke?_______ If yes, how many times a day: __________

Rate your stress levels on a scale of 1-10 during the average week: ______________

Please list any natural supplements you currently take and for what conditions:

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CARNES CHIROPRACTIC CLINIC, LLC.

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purposes of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

NAMES OF PEOPLE YOU MAY RELEASE MY HEALTH INFORMATION TO:

______________________________ Relation____________________ Phone____________
______________________________ Relation____________________ Phone____________
______________________________ Relation____________________ Phone____________
______________________________ Relation____________________ Phone____________
______________________________ Relation____________________ Phone____________

PLEASE CHECK ANY/ALL OF THE FOLLOWING WAYS WE ARE PERMITTED TO LEAVE PATIENT INFORMATION FOR YOU:

- ○ Information regarding my treatment may be left on my ___home phone ___work phone ___cell ___other
- ○ Information regarding appointments may be left on my ___home phone ___work phone ___cell ___other
- ○ I do not wish for any of my private information to be left on my home, work, cell or other phone

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

______________________________________ ______________________

Name of Patient Date

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name:____ Date of Birth:____________
(also list maiden name/other names used)

I hereby request and authorize:

Carnes Chiropractic & Wellness Clinic, LLC
2323 W Main St, Suite 109
Dothan, AL 36301

to disclose and/or receive Patient Health Information (PHI) on me for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.

This authorization will be effective unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

____Date_____________
Signature of Patient

OR

____Date_____________
Signature of Legal Representative/Relationship

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent or the patient or legal representative.