Creedmoor Wellness Center – Dr. Cheryl Hanly

1556 NC Hwy 56 W Creedmoor, NC 27522

Welcome to Creedmoor Wellness Center! Please read and fill out your new patient paperwork honestly and thoroughly. Your information is confidential and could be very relevant to your current condition. If you have any questions, please let us know.

First _____ MI _____ Last _____ DOB _____

Address_____

City _____ State _____ Zip Code _____

Cell _____ Home _____ Work _____

Email _____

Sex: _____ **Marital Status:** __Single __Married __Divorced __Widowed __Sig. Other

Your Current Employer & Occupation _____

Spouse's Name _____ Employer/Occupation _____

Children names/ages _____

Emergency Contact Name/Phone Number _____

Relationship to patient: _____

Primary Care Physician Name/Phone Number _____

Date of your last physical exam? _____

When was the last time that you felt well? _____

Please mark any supplements that you currently take: ___ fish oil ___ multi-vitamin

___ vitamin B ___ vitamin D Other_____

Are they taken regularly? _____ Recommended/prescribed by your doctor? _____

Please list all medications you are currently taking: _____

_____

_____

_____

_____

Please tell us about the problems or conditions that are concerning you.

Problem 1: _____

When did it start? _____ Possible cause? _____

How long have you been experiencing this issue? _____

What aggravates your symptoms: _____

_____

Was the onset: ___ sudden ___ gradual ___traumatic ___unknown

On a scale of 1-10 (10=severe) how would you rate your discomfort: _____

How often do you experience your symptoms?

___ Constantly (76-100% of the day) ___ Frequently (51-75% of the day) ___Occasionally (26-50% of the day) ___Intermittently (0-25% of the day)

Additional details: _____

_____

Problem 2: _____

When did it start? _____ Possible cause? _____

How long have you been experiencing this issue? _____

What aggravates your symptoms: _____

_____

Was the onset: ___ sudden ___ gradual ___traumatic ___unknown

On a scale of 1-10 (10=severe) how would you rate your discomfort: _____

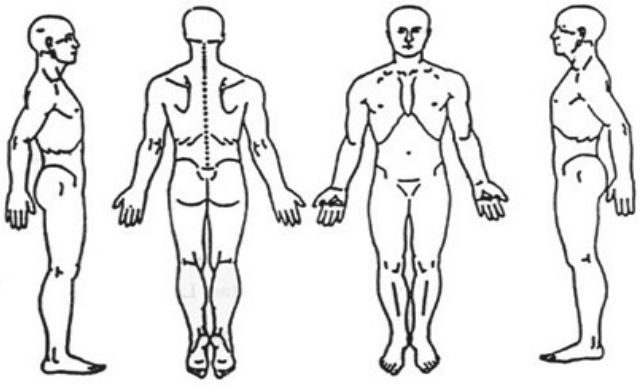
How often do you experience your symptoms?

___ Constantly (76-100% of the day) ___ Frequently (51-75% of the day) ___Occasionally (26-50% of the day) ___Intermittently (0-25% of the day)

Additional details: _____

_____

Please use the following body diagram to mark the areas of pain or discomfort.



Please check any that apply: __ slip and fall __ automobile accident __ boating accident __ motorcycle/bicycle accident __ other

Please list details for any that you selected: _____

_____

_____

_____

List <u>ANY</u> surgeries that you have had during your lifetime. Please list dates if possible.

_____

_____

_____

_____

How are you feeling today?

On a scale of 1-10 (10=severe) how would you rate your normal stress level? _____

What causes you the most stress? _____

Do you exercise? _____ **If yes, what type and how often.** _____

Please indicate your average use or consumption of the following.

Please include type, quantity and frequency.

Water: _____ Sodas: _____

Tobacco: _____ Sweets: _____

Alcohol: _____ Tea: _____

Coffee: _____ Recreational Drugs: _____

Do you have any specific food cravings? _____

Are they? ___ sour ___ bitter ___ sweet ___ spicy ___ salty ___ other

Please read through the following options and mark all that apply.

Neurologic
__ Fainting
__ Blackouts
__ Seizures
__ Numbness
__ Tingling
__ Tremors
__ Dizziness/Vertigo
__ Tics/involuntary motions
__ Convulsions
__ Memory Loss

Lungs
__ Persistent Cough
__ Phlegm/Mucus
Color? _____
__ Wheezing/asthma
__ Difficulty inhaling
__ Difficulty exhaling
__ Bronchitis
__ Pneumonia
__ Emphysema/COPD
__ Tuberculous
__ Pleurisy
__ Shortness of breath
__ Smoker
____ pkts/day ____ years
__ Ex-smoker
Date quit? _____
Date of last chest x-ray
_____
__ Other _____

Endocrine
__ Under-active thyroid
__ Over-active thyroid
__ Graves disease
When? _____
__ Hashimoto's thyroiditis
When? _____
__ Heat intolerance
__ Cold intolerance
__ Excessive sweating
__ Diabetes
When? _____
__ Excessive thirst
__ Excessive urination
__ Excessive hunger
__ Other _____

Hematologic
__ Anemia
__ Past transfusions
When? _____
__ Inherited bleeding diseases
__ Leukemia
When? _____
__ Hemorrhage/blood loss
Age? _____
__ Hepatitis
Type? _____
__ Other _____

Cardiovascular
__ Blood pressure Issues
__ Tightness/pain in chest
__ Difficulty lying flat
__ Irregular heartbeat
__ Pain over heart
__ Prior heart attack
Date? _____
__ Hardening of arteries
__ Prior stroke
Date? _____
__ Ankles swell
__ Poor circulation
__ Rheumatic/scarlet fever
__ Heart murmur
Date of last EKG _____
__ Restless legs
__ Varicose veins
__ Vein Surgery
__ Thrombophlebitis
__ Leg pains
__ Cold hands/feet
__ Hot hand/feet
__ Cold limbs
__ Other _____

Please read through the following options and mark all that apply.

General

__ Tremors
__ Fever
__ Convulsions
__ Lack of sleep
__ Fatigue-mental/physical
__ Nervousness
__ Anxiety/Panic Attacks
__ Depression
__ Confusion
__ Paralysis
__ Addictions
To? _____
__ Allergies
To? _____
__ Autoimmune Disease
__ Seasonal affective disorder
__ Numbness
__ Mood Swings
__ Overweight
__ Underweight
__ Unexplained weight loss
__ Other _____

Male ONLY

__ Urination difficulty or dribbling
__ Frequent nighttime urination
__ Prostate trouble
__ Other

Female ONLY

Are you currently pregnant? _____
Weeks? _____
__ Endometriosis
__ Painful menses/ovulation
__ Irregular cycles
__ Menstrual cramps
__ Mood swings
__ Excessive bleeding during cycles
__ Menopausal symptoms
__ Hot Flashes
__ Other _____

Eyes

__ Blurred Vision
__ Eyelid problem
__ Eye pain
__ Eye strain
__ Nearsightedness
__ Double Vision
__ Lazy Eye
__ Red, itchy, watery eyes
__ Glaucoma
__ Cataracts
__ Macular Degeneration
__ Nystagmus
__ Dry Eyes
__ Other _____

Skin

__ Bruise easily
__ Bleed easy/slow clotting
__ Excessively Dry
__ Psoriasis
__ Moles
__ Slow healing wounds
__ Sweating problems
__ Skin rash
__ Warts
__ Eczema
__ Oily
__ Other _____

Please read through the following options and mark all that apply.

Gastrointestinal/Digestion

__ Hiatal hernia/acid reflux/GERD
__ Parasites
When? _____
__ Stomach/duodenal ulcer
__ Black tarry stools
__ Pale stools
__ Liver issues
__ Rectal bleeding
__ Jaundice
__ Gallbladder issues
__ Difficulty losing/gaining weight
__ Recent rapid weight gain/loss
# of lbs. _____
__ Eating disorder
__ Food sensitivities/intolerance/allergies
__ Excessive hunger
__ Lack of appetite
__ Difficulty chewing food
__ Heartburn/reflux
__ Nausea
__ Vomiting
__ Belching/bloating/gas
__ Stomach/abdominal pain
__ Itchy skin
__ Hemorrhoids
__ Diarrhea
__ Loose stools
__ Constipation
__ Other _____

Genitourinary

__ Difficulty urinating
__ Burning/pain with urination
__ Incontinence/dribbling/leaking
__ Frequent urination
__ Blood in urine
__ Pus in urine
__ Discolored urine
__ Nighttime urination
How many times? _____
__ Bladder infections/cystitis
__ Kidney stones
__ Bedwetting
__ Other _____

Mouth & Throat

__ Issues with teeth
__ Loss of sense of taste
__ Unusual taste
__ Issues with gums
__ Tongue problems
__ Lump in throat
__ Problems with lips
__ Jaw problems
__ Speech problems
__ Sores in mouth
__ Secretions from tonsils or gums
__ Dentures/Implants
__ Sore throat
__ Hoarseness
__ Swollen glands
__ Goiter (swollen thyroid)
__ Difficulty swallowing
__ Burning in mouth
# of missing teeth _____
__ Other _____

Sleep

__ Lack of sleep
__ Wake feeling refreshed
__ Difficulty falling asleep
__ Difficulty staying asleep
__ Vivid/disturbing dreams
__ Difficulty staying asleep
__ Can't recall dreams
Awakened by:
__ pain
__ need to use restroom
__ noise (light sleeper)
__ Racing thoughts
__ Needs meds to sleep
__ Night sweats
__ Normally wakes at _____
__ Other _____

Please read through the following options and mark all that apply.

Musculoskeletal
__ Neck Pain
__ Mid back pain
__ Lower back pain
__ Painful tailbone
__ Spinal curvature/scoliosis
__ Bad posture
__ Hernia
__ Joint pain
__ Swollen joints
__ Hot, inflamed joints
__ Stiff joints
__ Arthritis
__ Sciatica
__ Issues with the feet
__ Difficulty walking
__ Sore/tired/weak muscles
__ Smothering sensations
__ Other _____

Ears
__ Hearing loss
__ Ear Pain
__ Ear Infections
__ Ear Discharge
__ Itching
__ Ringing
__ Excessive earwax
__ Flaky/dry skin in the ears
__ Other _____

Nose & Sinuses
__ Frequent Cold
__ Sinus Congestion
__ Nasal Discharge
Color? _____
__ Sores/lesions
__ Nosebleeds
__ Other _____

Head and Face
__ Discolorations
__ Headaches
__ Dizziness
__ Face Pain
__ Paralysis
__ Swelling
__ Numbness
__ Other _____

If there is any additional information that you would like to add, please do so below:

By signing below, I am stating that I have honestly and thoroughly completed the confidential new patient health history for Creedmoor Wellness Center. If I remember any additional information later, I will inform Dr. Cheryl and/or her staff immediately. I understand that it is my responsibility to provide my health information. I understand that by signing below, I cannot hold Dr. Cheryl or Creedmoor Wellness Center responsible for any misdiagnosis made as a result of my providing inaccurate or incomplete information.

Signed: _____ Date: _____

Creedmoor Wellness Center

Dr. Cheryl Hanly ~ 1556 NC Hwy 56 W Creedmoor, NC 27522
919-528-7290 (p) ~ 919-528-7297 (f)

Informed Consent Form

The nature of the chiropractic adjustment

The primary treatment used by Dr. Cheryl is spinal manipulative therapy. This is the procedure that will be used to treat you. She may use her hands or a mechanical instrument upon your body in such a way as to move your joints. An ***adjustment*** is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

The material risks inherent in chiropractic adjustments

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform our office.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bones, which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I _____ have read and fully understand the above statements. All questions regarding the doctors objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient signature: _____ Date: _____

Consent to evaluate and adjust a minor child

I _____, being the parent or legal guardian of _____ have fully read understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ CWC Staff

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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 purpose 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 affect 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, our office has the right to refuse to give care. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature_____ Date_____

CWC Staff_____