Welcome

Dr. Robert Twaddell and his staff at A Healthy Back welcome you and want to provide you with the best possible care. During the course of your treatment, I understand that I will be seen, evaluated and treated by a qualified healthcare professional. We know that filling out these forms can be annoying – but please complete them carefully. Your accurate responses will give us a better understanding of you and your problem. From this, we can provide you the best care possible.

Your First Visit

On your first visit, you will consult with the physician about your current symptoms. He will assess your history and condition to determine if you are experiencing any of the common signs of potential spinal "subluxations." These mis-alignments or fixations cause 'jamming' of the vertebrae in the spine that can cause nerve interference.

If this is the case, you will receive a full orthopedic and neurological exam and an x-ray referral will be made, if needed. This allows the doctor to determine your present condition and state of spinal health.

Report of Findings

Dr. Robert Twaddell will review your examination / x-ray findings with you, and let you know:

- What is **causing your pain** and/or symptoms?
- If he **can help you**?
- What **plan of treatment** is best for you?
- What plan of treatment is best for your condition?
- **How long it will take** (approximate)?
- What is **needed from you** to attain the best results?

Most likely, your condition can be helped with chiropractic care and after your report, you can be ready to begin your treatment.

We will also discuss with you an estimate of your potential care costs, and will gladly discuss your insurance coverage, and all of the options available to you for payment.

Initial Visit Payment

In order to determine if care can be of benefit to you, this office will extend a courtesy of an initial consultation and examination for $49. The most a new patient can expect to pay for a consultation, exam, and treatment is $95.00.

If treatment is provided during the initial visit, it will be discussed prior the given care. This amount is applied to your insurance co-pays until benefits have been qualified. Please be prepared to pay the initial visit charges.

I understand my payment of [ ] $49 Consult & Exam [ ] Up to $95 Consult, Exam, Treatment is due today.

If authorized, there is no initial visit payment for [ ] Auto Accidents or [ ] Veterans Choice

Informed Consent

I authorize the doctor and/or staff to perform the necessary services needed during diagnosis and treatment. I understand that the primary treatment used by doctors of chiropractic is the spinal adjustment. The doctor of chiropractic will use his hands or instrument in such a way as to move my joints. That may cause an audible pop or click much as experienced when one cracks their knuckles. I authorize the doctor of chiropractic to perform spinal adjustments to me. As part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy, acupuncture, spinal disc decompression, low level laser therapy, range of motion testing, muscle strength testing, radiographic studies, palpation, orthopedic testing, postural analysis, vital signs, basic neurological testing, and electrical stimulation.

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, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, burns, or stroke (one in 5 million cervical adjustments). Some patients will feel some stiffness and soreness following the first few days of treatment. I 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 my attention, it is your responsibility to inform the doctor.

I authorize the doctor and his staff to release any information deemed appropriate concerning my health care services to my insurance companies, health plan, claims adjuster, case nurse, claims reviewer, health care provider / MD, or attorney in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release them of any consequences thereof.

INFORMATION DISCLOSURE

Protecting the privacy of your personal health information is important to us. Disclosure of protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. Disclosures of protected health information are limited to the minimum necessary. This does not apply to the transfer of medical records.
We will periodically forward health care summaries to you in a secure format using Microsoft Health Vault. This service is free to you.
In the future, we may contact you for appointment visits, announcements, and to inform you about the practice and it's staff. Dr. Twaddell is required to abide by this notice. Dr. Twaddell has the right to change this notice in the future. Any revisions will be prominently displayed. You may file a complaint about privacy violations by contacting AHB.

Privacy preferences: Preferred method of phone contact: [ ] Home [ ] Cell [ ] Work

Leaving messages on answering machine (ie. appointments, results): [ ] Request no messages on phone

Family members allowed discussion of care with: [ ] No one [ ] ____

PATIENT INFORMATION

Today's Date: ________________ How did you hear about us? [ ] Patient [ ] Doctor [ ] Advertising _______________

Name: First, Middle, Last ____

Date of Birth ____________________ Age: _______ Gender (check one) [ ] Male [ ] Female

Marital Status (check one) [ ] Single [ ] Married [ ] Divorced / Separated [ ] Widowed [ ] Other

Employment Status (check one) [ ] Employed FT/PT [ ] FT Student [ ] PT Student [ ] Other [ ] Retired

SSN ____ Ages of children: ______________________________

Race (check one) [ ] White [ ] Black/African American [ ] Hispanic [ ] Multi-Racial [ ] ________________________

Contact Info

Address ____

City/State/Zip ____

Phone (H) ____________________________ (C) __________________________ (W) __________________________

Email [ ] Home [ ] Work ____

We do not give out your email to anyone. You will receive periodic healthcare updates and specials. You may opt out at any time.

Contact Method [ ] Home Phone [ ] Cell Phone [ ] Cell texts *(appt reminders)* [ ] Work Phone [ ] Email

Employment

Employer / School ___________________________________ Occupation ______________________________

Job Description ____

Employment Activities: ______________________________ Physical Stress Level: [ ] Low [ ] Medium [ ] High

Privacy

Verification Question **(choose only one question, then give the answer more than 6 characters to that question)**

[ ] What is the name of your favorite pet? [ ] What city were you born in? [ ] What high school did you attend?
[ ] What is your favorite movie? [ ] What is your mother's maiden name? [ ] What street did you grow up on?

Verification Answer to the Chosen question **(greater than 6 characters)**: ______________________________________

Family Information

Spouse or Parent Name: ____ Phone: ___________________________

Insurance [ ] Filing Insurance **Please provide card with paperwork** Insurance Company: __________________
CoPay: _________ Is Spouse/Parent Named Insured [ ] Yes Date of Birth: ____/____/______ [ ] No

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the information provided is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with the above stated carrier and assign directly to A Healthy Back all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that there is a $25 missed appointment fee that will be responsible for if not rescheduled with three hours notice. I authorize the use of my signature on all insurance submissions. A Healthy Back may use my health care information and may disclose such information to the above name insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ________________________________

Signature of patient, parent, guardian, or personal representative Date

CHIROPRACTIC ADVANTAGE PA. DBA A HEALTHY BACK
Dr. Robert Twaddell, Chiropractic Physician
1411 FT. BRAGG RD. FAYETTEVILLE, NC 28305
Phone: 910-303-2690 FAX: 910-728-4868

INITIAL CONSULTATION & EXAMINATION REPORT

Patient Name: ____

Date of Examination: ____/____/________ **Date of Birth:** ____/____/________ **Sex: [ ] M [ ] F**

The following is a report concerning the injuries, of the above named _________ year old patient, sustained as a result of an [ ] automobile accident [ ] ______________________________________ on _____/_____/______.

REGIONAL PAIN COMPLAINT(S) – Pain rating scale #1 - #10 with #10 being the worst pain

INITIAL COMPLAINTS **NOTES**

[ ] Headache [ ] Right [ ] Left [ ] Pain #: _____ ______________________

[ ] Front/Frontal [ ] Side/Temporal [ ] Back/ Occipital

[ ] Neck [ ] Right [ ] Left [ ] Pain #: _____ [ ] Numb ______________________

[ ] Pain [ ] Numbness [ ] Weakness radiating down (R / L) arm to [ ] Shoulder [ ] Elbow [ ] Hand

[ ] Trapezius [ ] Right [ ] Left [ ] Pain #: _____ [ ] Numb ______________________

[ ] Shoulder [ ] Right [ ] Left [ ] Pain #: _____ [ ] Numb ______________________

[ ] Elbow [ ] Right [ ] Left [ ] Pain #: _____ [ ] Numb ______________________

[ ] Wrist / Hand [ ] Right [ ] Left [ ] Pain #: _____ [ ] Numb ______________________

[ ] Fingers – List Digits ___________________________

[ ] Mid Back [ ] Right [ ] Left [ ] Pain #: _____ [ ] Numb ______________________

[ ] Low Back [ ] Right [ ] Left [ ] Pain #: _____ [ ] Numb ______________________

[ ] Pain [ ] Numbness [ ] Weakness radiating down (R L) leg to [ ] Hip [ ] Knee [ ] Feet

[ ] Buttocks [ ] Right [ ] Left [ ] Pain #: _____ [ ] Numb ______________________

[ ] Hip [ ] Right [ ] Left [ ] Pain #: _____ [ ] Numb ______________________

[ ] Knee [ ] Right [ ] Left [ ] Pain #: _____ [ ] Numb ______________________

[ ] Ankle / Foot [ ] Right [ ] Left [ ] Pain #: _____ [ ] Numb ______________________

[ ] Jaw/TMJ [ ] Right [ ] Left [ ] Pain #: _____ [ ] Numb ______________________

PREVIOUS TREATMENT & TESTS PERFORMED

[ ] NONE [ ] X-Rays ____/____/____ ______________________ [ ] MRI/CT ____/____/____ ______________________

[ ] Medications [ ] Injections [ ] PT / Traction [ ] Chiropractic [ ] Surgery [ ] ______________________

Providers Seen for this problem Specialty City Treatment

____

____

____

Self Treatments: [ ] OTC Medications [ ] Massage [ ] Ice [ ] Heat [ ] Rest [ ] Stretching [ ] Biofreeze [ ] ____________

PATIENT NAME: ___________________________________ DATE: ____/____/____

CURRENT CHIEF COMPLAINT

This patient presents with the **first** problem: [ ] Neck pain [ ] Back pain [ ] ___________________________________.
History of present illness/condition: The patient rated the intensity of their pain/symptoms as a _____ on a scale of 0 to 10 with zero being absence of symptoms and 10 being very severe / unbearable.

The symptoms began with [ ] injury [ ] onset on _____/_____/_________ [ ] Chronic over ______________ years.
The symptoms have been present [ ] constant (75-100%) [ ] frequent (50-75%) [ ] occasional (< 50%).
The patient described symptoms as worse in the [ ] morning [ ] throughout day [ ] evening [ ] night.

The patient describes their symptoms as radiating down the [ ] right arm [ ] left arm [ ] right leg [ ] left leg [ ] none
[ ] pain [ ] numbness [ ] tingling ([ ] shoulder [ ] upper arm [ ] lower arm [ ] hand) ([ ] buttock [ ] upper leg [ ] lower leg [ ] foot)

The patient describes their pain with the following qualifiers: [ ] dull [ ] sharp [ ] throbbing [ ] burning [ ] deep [ ] aching [ ] tingling [ ] stabbing [ ] cramping [ ] numbness [ ] radiating [ ] stiffness.

Upon questioning, they related that the symptoms were aggravated by activities including [ ] sitting [ ] standing [ ] walking [ ] bending [ ] stooping [ ] lifting [ ] sleeping [ ] sneezing [ ] coughing [ ] straining [ ] reaching [ ] twisting [ ] looking up / down [ ] movement [ ] rest [ ] lying supine / back [ ] driving [ ] typing [ ] scooping [ ] chores [ ] exercise [ ] lying prone / stomach.

The patient stated that some relief is obtained when [ ] sitting [ ] standing [ ] lying down [ ] knees are bent up [ ] leaning against a support [ ] no movement occurs [ ] movement occurs [ ] heat is applied [ ] ice is applied [ ] analgesic topical pain relief gel is applied [ ] ibuprofen is taken [ ] medication is used [ ] rest occurs [ ] stretching/exercise [ ] adjustments.

This patient presents with the **second** problem: [ ] Neck pain [ ] Back pain [ ] _________________________________.
History of present illness/condition: The patient rated the intensity of their pain/symptoms as a _____ on a scale of 0 to 10 with zero being absence of symptoms and 10 being very severe / unbearable.

The symptoms began with [ ] injury [ ] onset on _____/_____/_________ [ ] Chronic over ______________ years.
The symptoms have been present [ ] constant (75-100%) [ ] frequent (50-75%) [ ] occasional (< 50%).
The patient described symptoms as worse in the [ ] morning [ ] throughout day [ ] evening [ ] night.

The patient describes their symptoms as radiating down the [ ] right arm [ ] left arm [ ] right leg [ ] left leg [ ] none
[ ] pain [ ] numbness [ ] tingling ([ ] shoulder [ ] upper arm [ ] lower arm [ ] hand) ([ ] buttock [ ] upper leg [ ] lower leg [ ] foot)

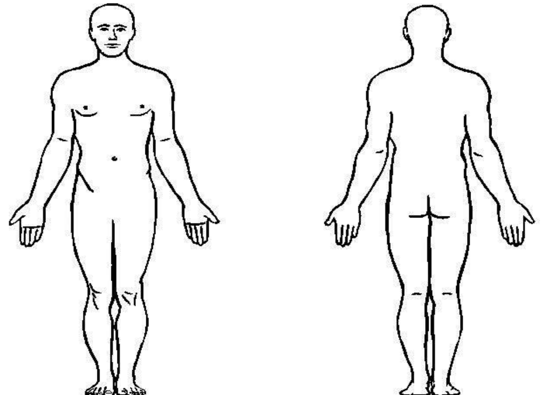
The patient describes their pain with the following qualifiers: [ ] dull [ ] sharp [ ] throbbing [ ] burning [ ] deep [ ] aching [ ] tingling [ ] stabbing [ ] cramping [ ] numbness [ ] radiating [ ] stiffness.

Upon questioning, they related that the symptoms were aggravated by activities including [ ] sitting [ ] standing [ ] walking [ ] bending [ ] stooping [ ] lifting [ ] sleeping [ ] sneezing [ ] coughing [ ] straining [ ] reaching [ ] twisting [ ] looking up / down [ ] movement [ ] rest [ ] lying supine / back [ ] driving [ ] typing [ ] scooping [ ] chores [ ] exercise [ ] lying prone / stomach.

The patient stated that some relief is obtained when [ ] sitting [ ] standing [ ] lying down [ ] knees are bent up [ ] leaning against a support [ ] no movement occurs [ ] movement occurs [ ] heat is applied [ ] ice is applied [ ] analgesic topical pain relief gel is applied [ ] ibuprofen is taken [ ] medication is used [ ] rest occurs [ ] stretching/exercise [ ] adjustments.

PLEASE DRAW ON DIAGRAM YOUR PAIN LOCATIONS:

Complaint Freeform / Additional note:



PAST COMPLAINT HISTORY

The patient [ ] has not [ ] has had previous episodes of complaints listed above.

PATIENT NAME: ____________________________________ DATE: ____/____/____

PREVIOUS MEDICAL / SURGICAL HISTORY

[ ] No Past Medical History

[ ] Heart Attack / Failure [ ] Abnormal Heartbeat [ ] High Blood Pressure [ ] Stroke / Concussion
[ ] Blood Clots Leg/Lung [ ] Poor Circulation [ ] High Cholesterol [ ] Asthma / Emphysema
[ ] Tuberculosis [ ] Thyroid [ ] Gastric Ulcers /Reflux [ ] Hiatal Hernia
[ ] Kidney Failure / Stones [ ] Rheumatoid Arthritis [ ] Osteoarthritis [ ] Gout / Osteoporosis
[ ] Cirrhosis / Hepatitis [ ] Bleeding Ds / Anemia [ ] Depression / Anxiety [ ] ADHD
[ ] Seizures [ ] Migraine / Headaches [ ] Fibromyalgia [ ] Cancer
[ ] Pregnant [ ] Other ____
[ ] Diabetes Controlled with [ ] Insulin [ ] Oral Medications [ ] Diet [ ] Neuropathy [ ] Hand [ ] Feet

Medications for medical condition: [ ] None ____

Medications for pain / complaint: [ ] None ____

Allergies: [ ] None ____

Surgeries (Dates): [ ] None ____

FAMILY/SOCIAL HISTORY

	Mother	Father	Siblings		Mother	Father	Siblings		Mother	Father	Siblings
Heart Disease	[ ]	[ ]	[ ]	Diabetes	[ ]	[ ]	[ ]	Stroke	[ ]	[ ]	[ ]
Lung Problems	[ ]	[ ]	[ ]	Cancer	[ ]	[ ]	[ ]	Arthritis	[ ]	[ ]	[ ]
Blood Pressure	[ ]	[ ]	[ ]	Bleeding Prob.	[ ]	[ ]	[ ]	Mental Illness	[ ]	[ ]	[ ]

[ ] Denies any alcohol consumption [ ] Denies any tobacco use [ ] Denies any recreational drug use.
[ ] Smoker ____ packs / week [ ] Quit smoking ___/______ [ ] Drink ____ / week [ ] Alcoholic [ ] History of drug use

REVIEW OF SYSTEMS

In the past 3 months have you experienced any of the following? [ ] No symptoms

Constitutional: [ ] Weight loss / gain [ ] Fever / chills [ ] Weakness / fatigue [ ] Anxiety [ ] Memory loss [ ] Lethargy [ ] Disorientated [ ] Irritability [ ] Balance [ ] Loss of consciousness [ ] Personality / cognitive changes

HEENT: [ ] Dizziness [ ] Visual loss / blurred / light sensitivity [ ] Hearing loss [ ] Ear pain / ringing [ ] Nose bleeds [ ] Teeth / gum problem [ ] Cough [ ] Trouble / sore swallowing [ ] Allergies / Sneezing / Congestion

Skin: [ ] Rash [ ] Itching [ ] Swollen glands / nodes [ ] Swollen joints [ ] Bleeding [ ] Bruising

Cardio / Respir: [ ] Chest pain / pressure / discomfort / palpitations [ ] Shortness of Breath [ ] Sleep Apnea / snoring

Gastrointestinal: [ ] Stomach pain [ ] Nausea / Vomiting [ ] Diarrhea [ ] Constipation [ ] Hemorrhoids [ ] Poor appetite

Genitourinary [ ] Urinary difficulty / changes [ ] Pregnancy Last menstrual period _____/_____ [ ] Painful / limited sex

Neurological: [ ] Headache [ ] Difficulty walking [ ] Numbness / tingling [ ] Muscular weakness [ ] Sensation loss

Primary Doctor Name: ______________________________ Phone: ____________________

Clinic Address: ____

Patient Signature: ____