Select Health
11535 Carmel Commons Blvd., #103
Charlotte, NC 28226
Phone: 704-541-5555

STAFF USE:
Today's Date: _____/_____/_____
Patient Acct # _____
Admin Staff Member Initials ⇨ _____

First Name: _____ **MI:** _____ **Last:** _____

Date of Birth: _____ / _____ / _____ **Social Security Number:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address: _____ **Apt / Unit / Condo:** _____

City: _____ **State:** _____ **Zip Code:** _____

Mobile Phone: (_____) _____ - _____ **Home Phone:** (_____) _____ - _____

Email: _____

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/er ☐ Other **Gender:** ☐ Male ☐ Female OR ☐ Gender Identity: _____

Emergency Contact Name: _____ **Ph Number:** (_____) _____ - _____

Ethnicity: _____ **OR** ☐ **Decline** **Primary Language:** _____ **Interpreter Needed?** ☐YES ☐NO

Occupation: _____

Employer: _____ **OR** ☐ Unemployed ☐ Self-employed ☐ Retired ☐ Disabled ☐ Student

First *and* Last Name of Your Primary Care Physician: _____

Have you seen any OTHER physician(s) for the condition that brought you to our office today? ☐ YES ☐ NO

If YES, First & Last Name of Physician Seen for THIS condition: _____

May we Release Your Health Information to this/these Physicians? ☐ YES ☐ NO

Other Persons or Facilities that we may Release Health Information to:

1. _____ **2.** _____

Health Insurance Company Name: _____

If Medicare, is there a Supplemental Plan? ☐ YES ☐ NO **If YES, Company Name:** _____

How were you referred to our office *(check all that apply)?*

☐ Google/Internet Search ☐ Facebook ☐ Instagram ☐ Radio ☐ Television ☐ Direct Mail
☐ Physician, Name: _____ ☐ Friend, Name: _____
☐ Family Member, Name: _____ ☐ Other: _____

Main Reason (Chief Complaint) for your visit today: _____

How Long have you had THIS condition? ☐Days ☐Weeks ☐Months ☐Years

Tests you have had for THIS condition: ☐MRI ☐Xray ☐CT ☐EMG ☐NCV ☐Other: _____ ☐None

Any Allergies to Medications/Supplements? ☐ YES ☐ NO **If Yes, List:** _____

Do you Currently take any of these Medications? ☐Neurotin ☐Gabapentin ☐Lyrica ☐Oxycodone ☐Percocet ☐Soma
☐Aleve ☐Tylenol ☐Ibuprofen ☐Chemo Meds/Trtmt ☐Diabetes Meds ☐Blood Prs Meds ☐Cholesterol Meds ☐None

Do you have any other condition you would like the doctor to discuss, such as?
☐Back Pain ☐Neck Pain ☐Sciatica ☐Bulging-Herniated-Degenerative Disc ☐Erectile Dysfunction ☐Plantar Fascitis
☐Knee Pain ☐Peripheral Neuropathy ☐Hip Pain ☐Pain in hands/arms/feet/etc. ☐Other _____ ☐Nothing

➤➤ **Patient Sign Here:** X _____ **Date:** _____/_____/_____

Providers Signature: _____

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Existing Condition Questionnaire for Contraindications Evaluation

Patient Name:_____

Date of Birth: _____ / _____ / _____

Are **YOU AWARE** of having any of the following?
Please answer ***each*** question below with a **" Y"** for Yes or **"N"** for No.

CONDITION	Y	N	CONDITION	Y	N
You are under the age of 18	☐	☐	Tumor or infection @ treatment site	☐	☐
Pregnancy	☐	☐	Severe Cardiovascular Disease	☐	☐
Surgical Hardware in the Spine	☐	☐	Uncontrolled Blood Pressure	☐	☐
Healing Spinal Fracture(s)	☐	☐	Malignancy, or Areas of Cancer	☐	☐
Healing Spinal Dislocation(s)	☐	☐	Steroid Injection less than 6 wks ago	☐	☐
Spinal Cord Compression	☐	☐	Bleeding Disorders (Hemophilia)	☐	☐
Destructive Lesions of the Spine	☐	☐	Thrombophlebitis	☐	☐
Extruded Disc Fragment(s)	☐	☐	Deep Vein Thrombosis (DVT)	☐	☐
Joint implants	☐	☐	Recent surgical wounds (unhealed)	☐	☐
Gross Spinal Instability	☐	☐	Acute or Recent Physical Injury	☐	☐
Local Bone Infections	☐	☐	Epilepsy	☐	☐
Spinal Neoplasm	☐	☐	Kidney Stones	☐	☐
Cauda Equina Syndrome	☐	☐	Gallstones	☐	☐
Bone Weakening Disease (Osteoporosis/Osteomalacia)	☐	☐	Inflammatory Disease/Rheumatoid Arthritis	☐	☐
Bilateral Pars Defect or Unstable Grade 2 Spondylolisthesis	☐	☐	Implanted Cardiac Device (implanted defibrillator, pacemaker, stent, etc.)	☐	☐

I certify the above to be a true and accurate representation of my health history.

➤➤**Patient Sign Here: X** _____ **Date:** _____/_____/_____

Provider Signature: _____