Welcome to TRIDENT CHIROPRACTIC
Data Entry Form

PLEASE PRINT

Date: _____ How did you hear about us? _____
Name: _____ Address: _____
City: _____ State ____ Zip: _____Home #_____ Work # _____
Cell #_____ Home Email: _____ Work Email: _____
Birth Date: ____/____/_____ M___F___ Marital Status: Married __ Single __ Other ___
SSN: _____ # of Children _____
Employment Status: Employed ___ FT Student ___ PT Student ___ Other ___ Retired ___ Self Employed ___
Occupation: _____Employer: _____
Spouse's Name: _____Spouse's SSN: _____
Spouse's Employer_____ Spouse's Birth Date: _____
Primary Insurance: _____Secondary Insurance: _____
Is this an injury related to an accident? If yes describe: _____
Primary Care Physician: _____ Hobbies:_____
Exercise Routine:_____
Please list all previous surgeries: _____
Please list any other health problems past or present for which you have been treated in the past ten years:
_____
Have you received previous chiropractic care? _____ What positions do you sleep in? ( ) Side ( ) Back ( ) Stomach

HEALTH HISTORY- Please mark the appropriate box for any disorders for yourself or family member. A family member is classified as Mother, Father, Brother, Sister, Son or Daughter.

	You	Family		You	Family		You	Family
Eyes, Ears	( )	( )	Intestines	( )	( )	Mental	( )	( )
Nose, Mouth, Throat	( )	( )	Stress	( )	( )	Diabetes	( )	( )
Blood Pressure	( )	( )	Urinary/Reproductive	( )	( )	Glands	( )	( )
Cholesterol	( )	( )	Joints/Muscles	( )	( )	Allergies	( )	( )
Cardiovascular	( )	( )	Skin	( )	( )	Energy	( )	( )
Lungs	( )	( )	Breast(s)	( )	( )	Sleep	( )	( )
Stomach/Digestion	( )	( )	Nerves	( )	( )	Immune	( )	( )

Briefly explain any "marked" answers with whom it affects and the condition:
_____
_____

Nutrition	None	Light	Moderate	Heavy	Nutrition	None	Light	Moderate	Heavy
Fruits	( )	( )	( )	( )	Chicken	( )	( )	( )	( )
Vegetables	( )	( )	( )	( )	Fish	( )	( )	( )	( )
Greens	( )	( )	( )	( )	Supplements	( )	( )	( )	( )
Nuts	( )	( )	( )	( )	Sweets	( )	( )	( )	( )
Bread/Grains	( )	( )	( )	( )	Water	( )	( )	( )	( )
Red Meat	( )	( )	( )	( )	Alcohol	( )	( )	( )	( )
Dairy	( )	( )	( )	( )	Tobacco	( )	( )	( )	( )
Oils/Fats	( )	( )	( )	( )					

List Supplements: _____

Race (check one)
( ) White ( ) Black/African American ( ) Hispanic ( ) American Indian/Alaskan Native
( ) Asian ( ) Asian Indian ( ) Chinese ( ) Filipino
( ) Japanese ( ) Korean ( ) Vietnamese ( ) Native Hawaiian or other Pacific Island
( ) Samoan ( ) Guamanian or Chamorro ( ) Other _____ ( ) I choose not to specify

Multi- Racial (check one)
( ) Yes ( ) No ( ) Unknown

Ethnicity (check one)
( ) Hispanic or Latino ( ) Not Hispanic or Latino ( ) I choose not to specify

Preferred language

( ) English	( ) Spanish	( ) American Sign Language	( ) Chinese	( ) French	( ) German
( ) Tagalog	( ) Vietnamese	( ) Italian	( ) Korean	( ) Russian	( ) Polish
( ) Arabic	( ) Portuguese	( ) Japanese	( ) Greek	( ) Hindi	( ) Persian
( ) Urdu	( ) Gujarati	( ) French Creole	( ) Armenian	( ) I choose not to specify	

Verification Question (Choose only one. Answer must be at least 6 characters)

( ) What is the name of your favorite pet? ( ) In what city were you born?
( ) What high school did you attend? ( ) What is your favorite movie?
( ) What is your mother's maiden name? ( ) On what street did you grow up?
( ) What was the make of your first car? ( ) When is your anniversary? ( ) What is your favorite color?

Answer: _____

Do you currently smoke tobacco of any kind? ( ) Yes ( ) Never ( ) Former smoker smoke-free since _____
If yes, how often do you smoke: ( ) Current every day smoker ( ) Current sometimes smoker
If yes, what is your level of interest in quitting smoking?
( ) 0 ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) 6 ( ) 7 ( ) 8 ( ) 9 ( ) 10
No interest *Very Interested*

Current medications, including dosage and frequency if known.
If there are no current medications, check here: ( )

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

List any known allergies or reactions to medications.
If no known allergies, check here: ( )

1. _____ 3. _____
2. _____ 4. _____

Has any doctor diagnosed you with Hypertension presently? ( ) Yes ( ) No

Has any doctor diagnosed you with Diabetes presently? ( ) Yes ( ) No If yes, what kind? ( ) Type I ( ) Type II

Fees are due when services are received unless special arrangements are made in advance. I understand and agree that health and accident insurance policies are an agreement between the insurance company or carrier and myself. Any amount authorized to be paid by the insurance company, carrier or legal representative shall be assigned and paid directly to Dr. Norman Bishop and will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me, whether I have health or accident coverage, are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my treatment any fees for professional services rendered to me are immediately due and payable including all reasonable collection costs and accrued interest charged on past due accounts. Past due accounts are subject to a 1.5 percent accrued interest charge. There is a $25.00 returned check fee.

Patient's Signature: _____ Date: _____
Legal Guardian's Signature: _____
(Authorizing treatment of a minor)

To be performed by clinic staff:

Height: _____ Weight: _____ BP: _____/_____ Pulse: _____

Station: L _____ R _____ Calipers: _____

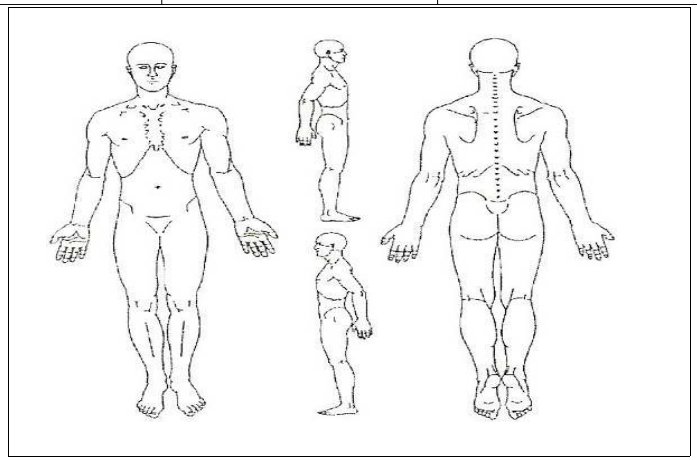
Please answer the following questions for each of your symptoms.

Location of pain? Pain intensity? **Circle one** 1 (minimal) to 10 (extreme pain) Date of onset?	What percent of the time does it hurt? 1-100 %	Is it worse in the morning, after noon or night ?	Is it dull, sharp, throbbing, burning, deep, aching, tingling, stabbing, cramping, numbness, radiating, stiffness	What makes the pain worse: sitting, standing, walking, bending, stooping, lifting, sleeping, sneezing, coughing, straining, reaching, twisting, looking up, looking down, movement, rest, lying supine, driving, typing, scooping, house chores, exercise, lying prone, stair stepping	What makes the pain better: sitting, standing, lying, knees bent up, support, no movement, movement, heat, ice, analgesic topical, ibuprofen, medication, rest, stretching/exercise, adjustments
Location: 0 1 2 3 4 5 6 7 8 9 10 Onset:	%				
Location: 0 1 2 3 4 5 6 7 8 9 10 Onset:	%				
Location: 0 1 2 3 4 5 6 7 8 9 10 Onset:	%				
Location: 0 1 2 3 4 5 6 7 8 9 10 Onset:	%				

Name:_____

Date:_____

Please place an X('s) over your symptom area(s)



Norman L. Bishop, D.C. 8988 University Boulevard Suite 103 North Charleston, SC 29406 (843) 764-3663

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short -form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of ___Norman L. Bishop, D.C._____.

I understand that the Notice describes the uses and disclosures of my protected health information by _____Norman L. Bishop, D.C._____ and informs me of my rights with respect to my protected health information.

This office may need to contact you by telephone with appointment reminders or to obtain or provide other information needed to provide service to you. Please list all telephone numbers we may use to contact you.

Home telephone _____

Work telephone_____

Cell phone _____

Other _____

____ If I am not available, you may leave a message via voicemail/answering machine

____ If I am not available, you may leave a message with a person who answers the telephone

Patient's Signature or that of Legal Representative

Printed Name of Patient or that of Legal Representative

Today's Date

If Legal Representative, Indicate Relationship

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

Employee Name

Today's Date

INFORMED CONSENT FORM (page 1)

PATIENT NAME: _____ DATE: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

spinal manipulative therapy	postural, spinal and extremity exercises	spinal and extremity adjustments
range of motion testing	palpation	vital signs
muscle strength testing	orthopedic testing	basic neurological testing
radiographic studies	postural analysis	cold therapy (ice or topical gel)
nutritional testing	Nervo-scope instrumentation	manual muscle therapy
posture support devices	nutritional therapy	

The material risks inherent in chiropractic adjustment.

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, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. 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 me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I 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 availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

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.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

INFORMED CONSENT FORM (page 2)

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Norman Bishop and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____
Patient's Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

Dated: _____

_____
NORMAN L. BISHOP, D.C.