Dr Shayla Coomer
CHIROPRACTIC PHYSICIAN

724 N. Jefferies Blvd.
Walterboro, SC 29488

1150 Hungryneck Blvd Suite C-320
Mt. Pleasant, SC 29464

843-732-3521
drshaylacoomer@gmail.com

Patient Information

Date____/____/_____

Name:_____ Sex: Male Female Birthdate:____/____/_____

Address:_____City:_____State:_____Zip:_____

Home Phone: (____)_____-_____Cell: (____)_____-_____ Work: (____)_____-_____

Email:_____ Preferred to be reached by: (circle one) Phone Text Email

Primary Care Physican:_____May we inform him/her about your care? Y / N

How did you hear about us?_____

Emergency Contact

Name:_____Relationship to Patient:_____

Home Phone: (____)_____-_____Cell: (____)_____-_____ Work: (____)_____-_____

Social History

Marital Status:_____

Pregnant: Y / N Due Date:_____

Occupation:_____

Employer/School:_____

Daily Stresses: (*circle all that apply*)

Sitting Standing Labor Repetitive Motion

Current Exercise Habits:_____

Habits: (*circle all that apply*)

Smoking-packs/day_____ Alcohol Caffeine

Family History

Is there a family history (mother, father, grandmother, grandfather) of any of the following condition(s)?

Cancer Y / N Who:_____

Stroke Y / N Who:_____

Diabetes Y / N Who:_____

Osteoporosis Y / N Who:_____

Heart Disease Y / N Who:_____

High Blood Pressure Y / N Who:_____

Alzheimer's Disease Y / N Who:_____

History of Illness / Injury / Pain

Chief complaint and its location: _____

What caused the onset?_____ Date of onset:____/____/_____

How often do you experience this pain? (*circle*) Constant Frequent Intermittent Occasional

Use the key below to help you answer the following questions:

0-None 1-Minimal 2-Very Mild 3-Mild 4-Mild to Moderate 5-Moderate 6-Moderate to severe
7-Mildly Severe, Restricts Some Activity 8-Severe, Limits Most Activity 9-Very Severe 10-Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10? ____

What is the least intense the symptom has been on a scale of 0 to 10?____

What is the most intense the symptom has been on a scale of 0 to 10?____

Associated Signs and Symptoms

How does this symptom affect other areas?
(*circle all that apply*)

R / L Arm Pain R / L Leg Pain Hip Pain Muscle Pain Muscle Spasm Neck Pain

Back Pain Shoulder Pain Other:_____

Quality

How would you best describe the sensation of the pain/symptom? (*circle all that apply*)

Sharp Dull Burning Prickly Shooting Numb Aching Stiffness

Throbbing Swelling Stinging Cramps Tingling Pins & Needles

Does this pain radiates or travel? Y / N Where to:_____

What aggravates the pain/symptom? (*circle all that apply*)

Reaching Coughing Standing Getting out of bed Carrying Lifting Sitting Depression

Pushing Straining at BM Bending Stooping Stress Emotional Upset Climbing stairs

Excercising Walking Looking side/side Driving Pulling Walking uphill Looking up/down

Walking Repetitive movement Getting in/out of car Other:_____

What Relieves this pain/symptom? (*circle all that apply*)

Resting Chiropractic Stretching Traction Heat Massage Ice

Muscle Cream Pain Medicine Nothing

Over the past weeks/months this complaint is: (*circle*) Improving Getting Worse About the same

Secondary Complaint

Location: _____

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10? ____

What is the least intense the symptom has been on a scale of 0 to 10?____

What is the most intense the symptom has been on a scale of 0 to 10?____

Quality

How would you best describe the sensation of the pain/symptom? (*circle all that apply*)

Sharp Dull Burning Prickly Shooting Numb Aching Stiffness

Throbbing Swelling Stinging Cramps Tingling Pins & Needles

Over the past weeks/months this complaint is: (*circle*) Improving Getting Worse About the same

Past Medical History

Please circle any of the following condition(s) that **YOU** have had:

Constitutional
Loss Of Consciousness
Fever/Chills
Recent Weight Change
Change In Appetite
Allergies

Ears/Nose/Mouth/Throat
Ringing In Ears

Cardiovascular
Chest Pain
High Blood Pressure
Heart Disease
Aneurysm
Take Blood Thinners

Respiratory
Difficulty Breathing
Asthma
Lung Condition

Endocrine
Thyroid Problem
Diabetes

Gastrointestinal
Reflux/Heartburn
Bowel Problems
Gall Bladder Problems
Liver Disease
Hernia

Genitourinary
Kidney Stones
Kidney Disease
Urinary Changes
Testicular Pain
Irregular Periods
Pregnancy

Psychiatric
Depression
Mood Changes
Panic Attacks / Anxiety

Integumentary
Skin Rash
Bruise Easily
Plastic Surgery

Musculoskeletal
Osteoporosis/Bone
Density Loss
Muscle Cramps
Muscle Weakness
Neuropathy
Arthritis
Restricted Motion
Joint Stiffness
Fibromyalgia
Difficulty Walking
Posture Problems
TMJ/Jaw Problems
Scoliosis
Fracture / Broken Bones
Carpal Tunnel Syndrome
Gout
Pinched Nerve
Bulging Disc
Multiple Sclerosis
Prosthesis

Neurological
Migraine Headaches
Slurred Speech
Confusion/Forgetfulness
Head Injury
Dizziness/Vertigo
Seizures
Stroke
Numbness/Tingling

Hematologic
HIV/AIDS
Anemia
Bleeding Disorders

Eyes
Vision Changes

Other
Tumor
Cancer

Is there anything else that you feel the doctor should know about you?_____

_____

Patient Signature:_____Doctor Signature:_____

Patient Office Policy

To Our Patients:

The following information is provided to familiarize you with the policies and procedures of Dr. Shayla Coomer, LLC and to allow us to serve you more completely.

Please initial after you have read each of the following:

_____**New Patients**
Initial visits are comprehensive information gathering sessions. Complete evaluation and review of your medical history are essential. In order to provide you with the most effective treatment, it is important that you complete the new patient documentation forms in as much detail and as accurately as possible.

_____**Insurance**
In an effort to keep costs down and still provide the best service for our patients, we have opted out of filing insurance claims. We feel that our fees are reasonable and fair. On the whole, deductibles, allowables, and copayments are higher than our fees. In this era of rising health costs, etc., we are doing our utmost to provide service at a fair cost.

_____**New Injuries**
In the event you sustain a new injury, please let the us know when you schedule your appointment. There may be additional paperwork to be filed, or Dr. Coomer may need to refer you for x-rays of the injured area and perform an exam of the injured area before being able to treat.

_____**Text Message Alerts / Phone calls**
We will either send a text message or call for appointment reminders to you on your provided cell phone number.

_____**Missed Appointments**
If you find it necessary to change your scheduled appointment, we ask that you do so on or before your confirmation text/call. If visit is canceled late or a "no show", you must pay for the missed appointment prior to being allowed to schedule a new appointment.

_____**Payment of Bills**
Payment is due at the time services are rendered. Our policy is that patients maintain a zero balance.

_____**Upsets**
We are here to serve you. Please speak with the staff or Dr. Coomer about anything that could be upsetting you (i.e. long waits, staff insensitivity, treatment confusion). We value your comments as helping us to help you and others.

_____**Photos/Testimonials**
You give us permission to use your testimonial and/or uploaded image on our website and for other marketing purposes.

I have read and understand the above policies and agree to abide by the above policies

_____ _____
Signature Date

CONSENT FOR CARE

By signing below, I give Dr. Shayla Coomer consent to provide chiropractic examinations and treatment. If the patient is a minor, I give consent to provide care to the above patient even if I am not with the patient on future visits. I understand that:

1. Chiropractors locate, analyze and gently correct spinal misalignments and joint fixations in order to contribute to health and correct musculoskeletal conditions. Correction of those misalignments can promote the restoration of normal motion, muscle function and nerve function.
2. Chiropractors do not prescribe drugs or perform surgeries. Chiropractors may, however, refer patients for medical services. Alternatives to chiropractic treatments have been explained; these may include over-the-counter medication, prescription medication, physical therapy, massage, home care activities, osteopathic manipulation and other treatments.
3. Chiropractic adjustments are usually safe when applied properly, but there are risks associated with chiropractic adjustments. There have been reports of fractures, muscle strains, sprains, and aggravation of disc conditions associated with some chiropractic procedures. There may also be temporary, minor musculoskeletal discomfort in the day(s) immediately following the adjustment as the muscles and other soft tissues adapt to the restored motion in my joints. Signing below indicates that any questions regarding these risks have been answered.
4. Massage, stretches, exercises, heat application, cold therapies, and various other treatments may be used to help patients manage their symptoms or to help them hold adjustments longer. These additional treatments carry their own risks, including burns, allergic reactions, sprains, strains, and aggravations of disc conditions amongst other complications. Signing below indicates that any questions regarding these therapies have been answered.
5. Patients are expected to comply with the doctor's home recommendations. Home care and follow-up visits enable our doctors to help patients attain maximum long-term results with the least possible investment of time, money and energy.
6. Patients are free to withdraw their consent and discontinue care at any time. Unless I do so, I intend for this written consent to cover the entire course of care for my present condition(s) and for any future condition(s) for which I seek treatment here.

AUTHORIZATION TO RELEASE INFORMATION AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES

By signing below I authorize the release of any medical, or other information necessary to diagnose or treat the above listed patient or to coordinate care with other healthcare providers who may be directly and indirectly involved in care. I also authorize the release of any medical or other information necessary to process insurance claims, obtain payment for health care bills from third-party payors, for coordinating care with other healthcare providers who may be directly and indirectly involved in care, and/or for conducting health care operations of Dr. Shayla Coomer such as quality assessment, accreditation or staff training. I also authorize Dr. Shayla Coomer to contact me by telephone, text, email, or mail, even if someone leaves a message with information about my care or my appointments at the numbers I provide them.

I have been provided with a copy of the Notice of Privacy Practices of Dr. Shayla Coomer and I understand that I have a right to review that Notice prior to signing this document. I understand that Dr. Shayla Coomer may change the privacy practices that are described in the Privacy Notice, and I may obtain a revised Notice by requesting it at any time. I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Shayla Coomer has taken action in reliance on this Consent.

I authorize release of any medical or other information to the following family members or individuals:

Name of Individual	Relationship to Patient	Name of Individual	Relationship to Patient

My signature below indicates my consent for chiropractic care and my authorization for use of my personal and health information. It also confirms that all information contained in the medical history forms I completed today is accurate and complete to the best of my knowledge. I understand that the analysis, diagnosis or treatment of my condition by Dr. Shayla Coomer may be contingent upon my consent as evidenced by my signature below. If I am signing for someone else, my signature also indicates that I am the legal guardian of the patient named above.

Signature of Patient or Guardian	Printed Name of Patient or Guardian
Date of Signing	Relationship to Patient

Health Insurance Portability and Accountability Act (HIPPA)

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Your Health Information Rights:

Although your health is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to;

Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522

d. Obtain a paper copy of the notice of information practices upon request
e. Inspect and copy your health record as provided for in provided by 45 CFR 164.524
f. your health record as provided in disclosures of your information as provided in 45 CFR 164.528
g. Obtain an accounting of disclosures of your information as provided in 45 CFR 164.528
h. Request communication of your health information by alternative means or at alternative locations
i. Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities: This Organization is required to:

a. Maintain the privacy of your health information
b. Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
c. Abide by the terms of this notice
d. Notify you if we are unable to agree to a requested restriction
e. Accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations.

We reserver the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us. We will not use or disclose your health information without your authorization, except as described in this notice.

My signature below indicates that I have been provided with the above information; the notice of privacy practices.

Patient Name (please print): **Signature:**

_____

Date: _____/_____/_____