PRIESTER Chiropractic
HandsOnWellness

Plese and Priester Chiropractic
1726 E. Seventh Street
Charlotte, NC 28204
P (704) 375 – 8264
F (704) 335 – 0940

A.J. Plese, DC
Chiropractic Physician

Authorization and Releases

Patient Name:_____

Consent to Professional Treatment
I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time.
Initial _____

Consent to Perform and Interpret X-Rays
I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of the practice and acknowledge that certain risk are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate.
I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service assigns benefits to be paid directly to that professional by my third party payor.
Initial _____

Females: Regarding Possibility of Pregnancy
This is to certify that, to the best if my knowledge, I am NOT pregnant. The doctor and certified staff have permission to perform diagnostic x-rays, particularly those involving the pelvis; can be hazardous to a fetus.
Initial _____

Females: Consent to X-Ray During Pregnancy
This is to certify that, I am or may be pregnant and that the doctor or certified staff has my permission to perform diagnostic x-rays involving any cervical spine (neck) or extremities (arms or legs), on the condition that lead shielding be used over the trunk of my body. I have been advised that certain x-rays, particularly those involving the pelvis, can be hazardous to a fetus.
Initial _____

Assignment of Benefits and Release of Records
I hereby assign to the practice all of my medical and procedure benefits to which I am entitled, including major medical benefits for services rendered. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plan to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.
I hereby authorize this practice to release any medical or other information required by third party payers, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me be the practice.
Initial _____

Financial Obligation
I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees insured, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance company receives claim.
Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and aby and all other expense s incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.
You may direct any questions regarding this financial obligation to the clinic manager or physician.
Initial _____

Signature _____ Date _____

PRIESTER Chiropractic
HandsOnWellness

A.J. Plese, DC
Chiropractic Physician

Plese and Priester Chiropractic
1726 E. Seventh Street
Charlotte, NC 28204
P (704) 375 – 8264
F (704) 335 – 0940

Personal Information

Full Name: _____
Last First M.I. Jr / Sr

Address: _____
Street Address Apartment/Unit Number

_____
City State Zip Code

Primary Phone: _____ H / M / B Alternate Phone: _____ H / M / B

Date of Birth: ____/____/____ How did you hear about us? _____

Gender: ☐ Male ☐ Female

Email Address: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Health Insurance? ☐ No ☐ Yes Are you the responsible party on your health insurance? ☐ Yes ☐ No

If no, your relationship to the responsible party (parent, spouse, etc.): _____

Responsible parties date of birth: ____/____/____

Employer Information

Your Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired ☐ Student

Occupation or Title: _____

Employer Name: _____

Employer Address: _____
Street Address Apartment/Unit Number

_____
City State Zip Code

Employer Phone: _____ Fax: _____

Start Date: ____/____/____ End Date: (If you're no longer working here.) ____/____/____

PRIESTER Chiropractic
HandsOnWellness

A.J. Plese, DC
Chiropractic Physician

Plese and Priester Chiropractic
1726 E. Seventh Street
Charlotte, NC 28204
P (704) 375 – 8264
F (704) 335 – 0940

Patient Name: _____

Prescription Medications

Prescription medications taken on a regular or ongoing basis:

Medication: _____ Dosage: _____ Frequency: per ☐ Day ☐ Week ☐ Month

Other: _____

Medication: _____ Dosage: _____ Frequency: per ☐ Day ☐ Week ☐ Month

Other: _____

Medication: _____ Dosage: _____ Frequency: per ☐ Day ☐ Week ☐ Month

Other: _____

Cancer History

Check if a physician has ever diagnosed you with Cancer. ☐ Yes

Check all that apply

☐ Bladder	☐ Kidney (renal cell)	☐ Skin
☐ Brain	☐ Leukemia	☐ Basal cell Carcinoma
☐ Breast	☐ Lung	☐ Squamous Cell Carcinoma
☐ Cervical	☐ Non-Hodgkin's Lymphoma	☐ Melanoma
☐ Colon or Rectal	☐ Ovarian	☐ Stomach
☐ Endometrial	☐ Pancreatic	☐ Thyroid
☐ Eye	☐ Prostate	☐ Uterine

Other: _____

PRIESTER Chiropractic
HandsOnWellness

A.J. Plese, DC
Chiropractic Physician

Plese and Priester Chiropractic
1726 E. Seventh Street
Charlotte, NC 28204
P (704) 375 – 8264
F (704) 335 – 0940

Patient Name: _____

Chief Complaint

Case Title: _____

Describe the reason for you visit: _____

_____

_____

When did your symptoms begin? (Select one)

☐ Today ☐ This week ☐ Last week

☐ 3 – 6 Months ☐ 6 – 12 Months ☐ 12 Months or More

For Women Only: Most recent menstrual cycle: ____/____/____

Are you pregnant? ☐ Yes ☐ No

Which word describes the frequency of your discomfort? (Select one)

☐ Constant ☐ Intermittent

☐ Occasional ☐ Rare

Which phase does best describe ***changes*** in your discomfort during the **day**? (Select one or more)

☐ Is worse in the morning ☐ Is worse in the afternoon ☐ Is worse at night

☐ Changes with the weather ☐ Does not change

What helps ***relieve*** your discomfort? (Select one or more)

☐ Ice ☐ Heat ☐ Medication ☐ Other (please describe) _____

What activities are limited by your discomfort? (Select one or more)

☐ Bending ☐ Bowel Movements ☐ Coughing ☐ Daily Routine

☐ Driving ☐ Getting Up ☐ Lifting ☐ Lying Down

☐ Pulling ☐ Pushing ☐ Reading ☐ Sitting

☐ Sleeping ☐ Sneezing ☐ Standing ☐ Turning my head

☐ Urination ☐ Walking ☐ Working ☐ Other (please describe) _____

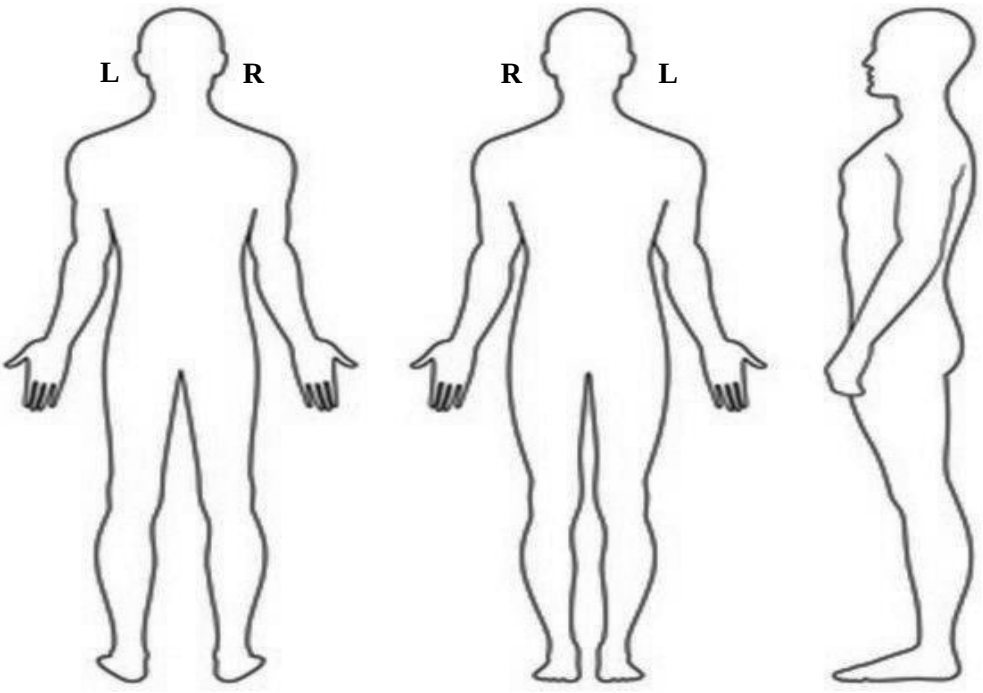
PRIESTER Chiropractic
HandsOnWellness

A.J. Plese, DC
Chiropractic Physician

Plese and Priester Chiropractic
1726 E. Seventh Street
Charlotte, NC 28204
P (704) 375 – 8264
F (704) 335 – 0940

Patient Name: _____

Symptom Illustrator



Back **Front**

1 Identify your area of discomfort by marking the affected body parts in the illustration.

2 Indicate the area name along with your specific symptoms associated with each selected area.

3 Rate your discomfort associated with each selected area.

2		Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Numbness	Swelling	Stiffness	**3** 0 – No Discomfort 10 – Severe Discomfort
Ex	L X Lower Back			X			X				X	1 2 3 4 5 6 X 8 9 10
1.	L R											1 2 3 4 5 6 7 8 9 10
2.	L R											1 2 3 4 5 6 7 8 9 10
3.	L R											1 2 3 4 5 6 7 8 9 10
4.	L R											1 2 3 4 5 6 7 8 9 10