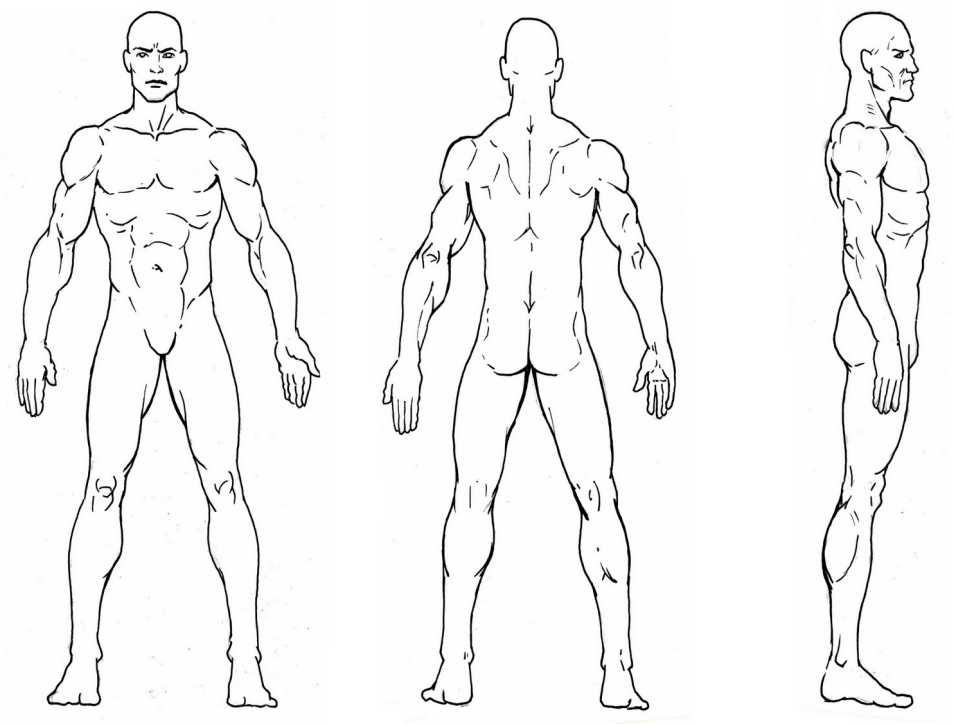
GOLDSBORO™
SPINE CENTER

605 N Spence Avenue Goldsboro, NC 27534
Ph ☎: 919-751-0555; Fax: 919-751-3001
✉ goldsborospinecenter@hotmail.com
www.goldsborospinecenter.com

# RE-ACTIVATION OF CARE

According to our records, the date of your last visit was on:_____
Please let us know if any of your contact information has changed:
Name:_____
Address:_____
Home Phone: _____ Mobile:_____ Work:_____
Email Address:_____Date of Birth:_____
I prefer to be contacted by: ❑Home ☎ ❑Mobile ☎ ❑Work ☎
Occupation:_____ Employer:_____
Reason for today's visit:_____
Please mark the areas of your complaint on the illustration below. Use the following letters to indicate the area and symptoms: P= Pain N=Numbness T=Tenderness S=Spasm



Check if you have symptoms or pain in the following areas:

❑Headaches
❑Neck
❑Shoulder
❑Arm ❑Elbow
❑Wrist ❑Hand
❑Upper Back
❑Lower Back
❑Hip ❑Leg
❑Knee ❑Ankle
❑Foot

Mark the words that describe your pain:
❑Dull ❑Ache ❑Sharp ❑Shooting ❑Stabbing ❑Burning ❑Numb

How long have you had this condition?_____years_____months_____days
Have you had this condition in the past?_____

Is this condition interfering with your ❑work ❑sleep ❑daily routine

❑other: Please describe:_____

Since your last visit, have you had any:

❑ Injuries (Falls, Accidents)

❑Activities (Pain Caused by too much Gardening)

❑Conditions (New Medications, New Diagnosis, New Health Problems)

Please describe:_____

Have you have any: ❑Surgeries ❑Chiropractic Care ❑Medical Care ❑Physical Therapy

Please list name of provider and condition:_____

**For Women Only: To your knowledge, are you pregnant? ❑Yes ❑No**

**Medication List: Please list Dosage:**

| Prescriptions | Over the Counter (Tylenol) |
|---|---|
| | |

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign This Acknowledgement***

**I, _____, have received and had the opportunity to review a copy of Goldsboro Spine Center's Notice of Privacy Practices. I understand that the Notice describes the uses and disclosures of my protected health information and informs me of my rights with respect to my protected health information.**

**For Office Use Only**

**We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:**

**❑Individual refused to sign**

**❑Communications barriers prohibited obtaining the acknowledgement**

**❑An emergency situation prevented us from obtaining acknowledgement**

**❑ Other (Please Specify)**

**Signature:_____**

**Date:_____**

**REVIEW OF SYSTEMS**

For established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, PLEASE CIRCLE THE ONES THAT APPLY, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

**Const. (Health in General)** ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____

**Ears, Nose, Mouth & Throat** ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

**C-V (Heart & Blood Vessels)** ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

**Resp. (Lungs & Breathing)** ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

**GI (Stomach & Intestines)** ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

**GU (Kidney & Bladder)** ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

**MS (Muscles, Bones, Joints)** ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

**Integ. (Skin, Hair & Breast)** ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

**Neurologic (Brain & Nerves)** ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

**Psychiatric (Mood & Thinking)** ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

**Endocrinologic (Glands)** ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

**Hematologic (Blood/Lymph)** ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

**Allergic/Immunologic** ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

**Signature:**_____

**Date:**_____

Chiropractic Authorization, Release, & Explanation
Goldsboro Spine Center
605 N Spence Ave
Goldsboro, NC 27534
(919)751-0555

Medical Notes and X-Ray Release

I hereby acknowledge the release of medical information, S.O.A.P notes, and x-ray reports, to Goldsboro Spine Center, Dr. Wayne P. Wagner, and treatment of my condition.

| | |
|---|---|
| _____ | _____ |
| Patient Name (please print) | Date of Birth |
| _____ | _____ |
| Patient Signature | Date |
| _____ | _____ |
| Witness Signature | Date |