Dynamic Health Carolinas
4705 South Blvd. | Charlotte, NC 28217 | 704-525-6288 | www.dynamichealthcarolinas.com

Basic Patient Information

Date: _____

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address: _____

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

Home Phone: (___) _____-_____ **Work Phone:** (___) _____-_____ **Cell Phone:** (__) _____-_____

Date of Birth: _____/_____/_____ **Sex:** ☐Male ☐Female **Email:** _____

Social Security Number: _____-_____-_____ (optional for Insurance purposes only)

Marital Status: ☐Single ☐Married ☐Other

Employment Status: ☐Employed ☐Full Time Student ☐Part Time Student ☐Other (check one)

Employer

Company Name: _____

Emergency Contact

Name: _____ Contact Number: _____

Primary Care Physician

Name: _____ Practice Name: _____

Insurance Information

*** Please provide us with your insurance card to scan. ***

Please fill out if patient differs from policy holder

Policy Holder: ☐Spouse ☐Parent/Guardian ☐Other_____ **Policy Holder Date of Birth:** _____/_____/____

Policy Holder First Name: _____ **MI:** ___ **Last Name:** _____

Policy Holder Social Security Number: _____ (optional for Insurance purposes only)

Treatment Authorization

I hereby authorize this office and its staff and doctors to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount become necessary, I will become responsible for all charges, fees and attorney fees. I (we) hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient's Signature _____ **Date:** _____

Acknowledgement of Receipt

As required by the Privacy Regulation, I hereby acknowledge that I have received a current copy of the Dynamic Medical Group Notice of Privacy Practices, Bill of Rights and Responsibilities.

Staff can be reached Monday-Thursday from 10am-7pm and Friday 10am-2pm at 704-525-6288. After hours call 704-525-6288 and the after hours Doctor will respond.

I am aware that the Dynamic Medical Group has included a provision that it reserves the right to change the terms of this notice and to make the new notice provisions effective for all Protected Health Information that it maintains.

Patient's Signature _____ **Date:** _____

If signed by a representative of the patient:
Representative's Name _____ **Relationship**_____

Dynamic Health Carolinas

4705 South Blvd. | Charlotte, NC 28217 | 704-525-6288 | www.dynamichealthcarolinas.com

Initial Medical Screening Questionnaire

Name: _____ Date: _____

Recent Illness: _____ Fever: Y / N

Allergies:( ) None ( ) Penicillin ( ) Sulfa ( ) Shellfish ( ) Citrus

Medical History:

_____ _____

_____ _____

Family History: Please circle all that apply: Heart Disease Stroke Diabetes Cancer _____

Surgical History: Joint Repair/Replacement? Y / N Spine Surgery? Y / N

Please let us know if YOU HAVE or HAVE HAD any of the following conditions: (circle all that apply)

Chronic Allergies/Recent Colds/Flu/Cough	Yes	No	
Cancer of the (_____)	Yes	No	
Thyroid Problems/Chronic Steroids/Autoimmune Disease	Yes	No	
Hepatitis/ AIDS/ HIV+	Yes	No	
Diabetes	Yes	No	Recent A1C_____
Stroke / Chronic Headaches / Seizures	Yes	No	
Heart / Blood Vessel Problems	Yes	No	
Pacemaker / Cardiac Stents / Artificial Valves	Yes	No	
Chronic Blood Thinners	Yes	No	
High Blood Pressure	Yes	No	
Bone Disease / Broken Bones / Artificial Joints / Screws	Yes	No	
If Yes, Which Bones? _____			
Prostate Disease / Hormone Therapy	Yes	No	
Alcohol Addiction / Depression / Anxiety	Yes	No	
COPD/CHF/Asthma/Shortness of Breath? Wheezing/ Emphysema	Yes	No	
Recent Bronchitis/ Pneumonia/Bronchospasm	Yes	No	
Used Illegal or IV Drugs	Yes	No	
Chiropractic Treatment Before	Yes	No	
Are you or do you think you **may** be pregnant?	Yes	No	

Please explain any "YES" above:

Medications: **Please provide a written copy of ALL your medications, including ones over the counter, vitamins and supplements**

Dynamic Health Carolinas
4705 South Blvd. | Charlotte, NC 28217 | 704-525-6288 | www.dynamichealthcarolinas.com

PATIENT NAME:_____ **DATE OF BIRTH:** _____

REVIEW OF SYSTEMS: Check if you have ***current symptoms or current known*** medical problems during the **last month** in the following areas. Please describe. If you do not have any problems, please check the ***None*** box.

Constitutional General	□ None □ Fever/Chills □ Weight Gain/Loss □ Weakness □ Chronic Tiredness/Fatigue □ Other:_____
Eyes	□ None □Vision Change □ Eye Pain □ Tearing/Dry Eye □ Sensitivity to Light □ Black Spots □ Other:_____
Ears, Nose, Throat	□ None □ Loss of Hearing □ Loss of Smell □ Loss of Taste □ Sinus Pain □ Sore Throat □ Other:_____
Cardio	□ None □ Chest Pain □ Shortness of Breath □ Racing Heart □ Swollen Legs □ Leg cramps □ Heart Murmur □ Difficulty Lying Flat □ Frequent Urination at night □ Varicose veins □ Other:_____
Respitory	□ None □ Difficulty Breathing □Wheezing □ Frequent Cough □ Coughing up Blood □ Other:_____
GI	□ None □ Heartburn □ Indigestion □ Acid Reflux □ Belching □ Vomiting Blood □ Ulcer Problems □ Abdominal Pain □ Blood in Stool □ Nausea/Vomiting □ Diarrhea □ Other:_____
Skeletal	□ None □ Joint Pain/Stiffness/Locking □ Muscle Weakness □ Decreased Motion □ Back Pain □ Neck Pain □ Injuries □Muscle Cramps □ Muscle Twitching □Swelling □ Other:_____
Skin	□ None □ Rash □ Ulcers □ Scars □ Hives □Excess Hair Growth/Loss □ Other:_____
Neurological	□ None □ Headaches □ Numbness/Tingling □ Tremors □ Seizures □ Dizziness □ Imbalance □ Other:_____
Psychiatric	□ None □ Depression □ Mood Swings □ Anxiety □ Confusion □ Crying □ Appetite Change □ Trouble Sleeping □ Memory Loss □ Other _____
Endocrine	□ None □ Increased Hunger □ Increased Thirst □ Increased Urination □ Hot Flashes □ Other:_____
Hematology	□ None □ Easy Bruising □ Bleeding □ Anemia □ Other:_____

MEDICATION LIST: Please include all prescribed and over the counter medications and also all vitamins and supplements you are currently taking.