

COLLABORATIVE

HEALTHCARE

CHIROPRACTIC & PHYSICAL MEDICINE
THE NEW WAY

Dear Patient:

Welcome to the online paperwork. We developed this paperwork to streamline your new patient appointment, reducing the time you spend sitting in our office and increasing the time our providers can spend with you. Please take the necessary time to complete this questionnaire, being as thorough as possible. We want you to know that it is our sincere desire to help in any way we can, and your answers will assist us in helping you.

This document should be used as an online tutorial, and will highlight areas throughout the online paperwork that will assist you in providing us with a comprehensive health history. Click on the link below to open the online paperwork. We recommend you briefly look over this document before starting the paperwork and refer back to this document as needed throughout the process. Thank you.

[Click here to start.](#)

** Please allow adequate time to finish the online paperwork completely. Currently there is no “save” option, so you will be asked to complete and submit all the information at once. The image below is directly from the online paperwork.

For your protection and security; Navigating away from this form before clicking the [Submit] button will dismiss all completed form fields. Successful submission will redirect you to a confirmation page.

** The online paper work will prompt you through the questionnaire. When questioned about your symptoms – start with your “chief complaint,” which is the area that is most bothersome to you.

Where is the discomfort?

Select only one area of discomfort for your chief complaint. Add additional areas of discomfort as additional complaints by selecting **Yes** in response to **Do you have an additional complaint?** at the bottom of this section.

If you have more than one area of complaint (i.e. neck pain and low back pain), you will be prompted with the question below. (You may have several areas of discomfort – this prompt will continue to appear and allow you to enter each area).

Do you have an additional complaint?

Yes No

[\(Back to Top\)](#) | [\(Go to Submit\)](#)

Review of Systems

Be sure to click “yes” to allow for a further description of your additional areas of complaint, as seen below.

Do you have an additional complaint?

Yes No

Complaint #2 Information

What is the purpose of your visit?

**The Review of System is very important and give us a general insight to your overall health and can help alert us to potential risks associated with your current condition.

Review of Systems

Musculoskeletal

No additional musculoskeletal complaints Additional musculoskeletal complaints

Neurological

Under each of these sections, please click on “additional... complaints,” this will allow a list of conditions to be viewed, please review this list and indicate any that are relevant to your health. If none of those are relevant, click on “No additional ... complaints.”

Review of Systems

Musculoskeletal

No additional musculoskeletal complaints Additional musculoskeletal complaints

Osteoporosis

Arthritis

Scoliosis

Joint or muscle pains/stiffness

Cramping

Swelling, redness deformity of joint(s)

Fractures

Implants, plates, pins or screws

Neck pain

Back problems

Hip disorders

Knee injuries

Foot/ankle pain

Shoulder problems

Elbow/wrist pain

Poor posture

Gout

Neurological

**A similar process will occur under “Past, Family and Social History.” Under “Past Surgeries,” you will be given 2 options.

Past, Family and Social History

List your (or the patient's) past surgical history. Choose all that apply and indicate the year in which the surgeries were performed.

Yes, surgical history

No surgical history

Please click "yes, surgical history which will provide you list of procedures to review (shown below). Indicate any that are to your health history. If have not had any of these procedures, click on "No surgical history."

Past, Family and Social History

List your (or the patient's) past surgical history. Choose all that apply and indicate the year in which the surgeries were performed.

Yes, surgical history

No surgical history

Abdominal aortic aneurysm repair Year:

Appendectomy Year:

Biopsy Year:

Bunionectomy Year:

**This process will be repeated at the next section you reach which will address any "Past Illnesses."

Describe any past illnesses or conditions the doctor should be aware of and the age at which the illness(es) reportedly occurred. Respond respectively to each illness listed. If personal health history is good, select "No past illnesses (including diabetes, cancer, hypertension and progressive neurological diseases)"

Yes, past illnesses

No past illnesses (including diabetes, cancer, hypertension and progressive neurological diseases)

Again, please click "Yes, past illness," and review the options that will be provided (Shown below). Indicate any past illnesses you have experienced. If no past illnesses are relevant to your health history – click "no past illnesses" and proceed with the questionnaire.

Describe any past illnesses or conditions the doctor should be aware of and the age at which the illness(es) reportedly occurred. Respond respectively to each illness listed. If personal health history is good, select "No past illnesses (including diabetes, cancer, hypertension and progressive neurological diseases)"

Yes, past illnesses

No past illnesses (including diabetes, cancer, hypertension and progressive neurological diseases)

Number of children:

Number of pregnancies:

Number of deliveries

AIDS/HIV Age:

Alcoholism Age:

Alzheimer's Age:

**There will be a section FOR MEN ONLY and a section FOR WOMEN ONLY (Shown below). Fill out only the section that is appropriate for you, skip the section that is not appropriate for you.

For Men Only

COMPLETE THIS SECTION ONLY IF YOU ARE (OR THE PATIENT IS) A MAN OVER 16 YEARS OF AGE.

For Women Only

COMPLETE THIS SECTION ONLY IF YOU ARE (OR THE PATIENT IS) A WOMAN OVER 16 YEARS OF AGE.

**If you are involved in an open workers compensation claim, or if your injury happened at work (even if you do not have an open claim) – please fill out the section titled “Workers Compensation” (Shown Below) If you are unsure if this applies to you – please contact our office at 803-359-2273 and we can assist you in determining how to proceed. If you are confident this does not apply to you, skip this section and proceed through the questionnaire.

Worker's Compensation

Who saw the accident?

Title:

**Authorization – please read this section thoroughly.

Authorization

***** AUTHORIZATION TO RELEASE INFORMATION ***** . . I hereby authorize the Doctor

Once you have read this statement thoroughly, if you “agree with this statement of authorization” – please click the box that indicates such (shown below).

I agree with this statement of authorization

Signature

You will then be prompted for a signature, you can sure your mouse to perform this.

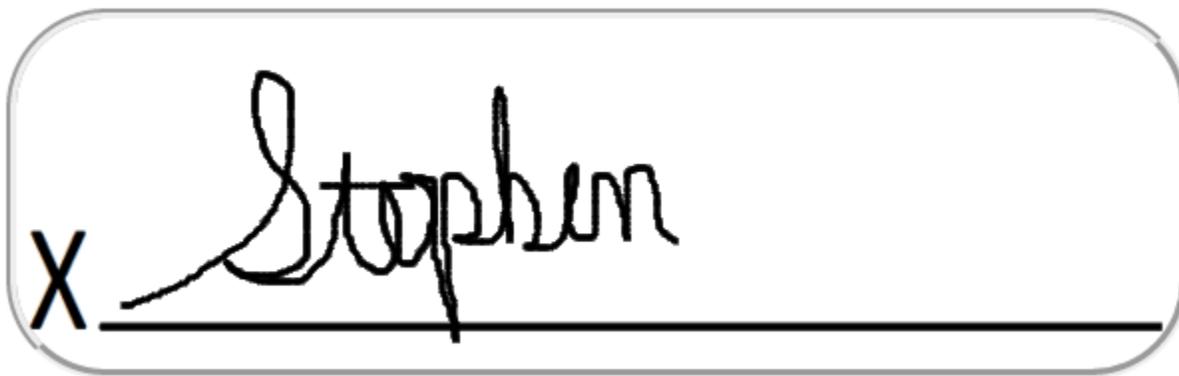
Signature



Clear Signature

To sign using your mouse - press and hold down the left mouse button and sign in the area provided. This MUST BE COMPLETED before everything is submitted.

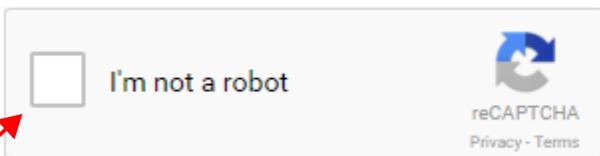
Signature



Clear Signature

**You will then click "I'm not a robot" which may prompt you through a question (some have images) – answer to the best of your ability and submit. This process cuts down on "SPAM" and verifies that all paperwork submitted is from actual patients.

2.



At this point there is one last step – if you'd like, now would be a great time to review your online paperwork before submitting. After review, simply press "Submit Form" (Shown below).

3. Submit Form!

Submit Form

Thank you for completing the online questionnaire. This will serve as your new patient paperwork, and should significantly reduce "waiting" time in our office. We look forward to meeting you soon.