Patient Name: _____

Date: _____

Ivey O'Sullivan Healthcare Services, PA
Dr. Gabriel O'Sullivan, DC
Dr. Stacy Gantt, DC
Dr. Suzzanne Candelaria-Perez, DC
Dr. Michael Neal Quinn, DC
201 S Dean Street, Spartanburg, SC 29302
P: 864.583.3967 F: 864.585.5554

Consultation Questionnaire

Major symptom/chief complaint: _____

Date symptoms appeared or accident happened: _____

Is this due to: ❑Auto Accident ❑Work ❑Other _____

What does this prevent you from doing or enjoying? _____

Have you ever had the same or similar condition? ❑Yes ❑No

If yes, when and describe: _____

Has the condition become worse recently? ❑Yes ❑No

If yes, when and describe:_____

How frequent is your condition? ❑Constant ❑Daily ❑Intermittent ❑Night Only

How long does it last? ❑All Day ❑Few Hours ❑Minutes

Are there any other conditions or symptoms that may be related to your major symptom? ❑Yes ❑No

If yes, describe: _____

Check those that describe your pain: ❑Sharp ❑Dull ❑Numbness ❑Tingling ❑Aching ❑Burning ❑Stabbing

❑Other_____

Place an "X" on the line below to indicate severity of the problem.

No Symptoms ---------- Extreme Symptoms

0 1 2 3 4 5 6 7 8 9 10

Is there anything you can do to relieve the problem? ❑Yes ❑No

If yes, describe: _____

If no, describe what you have tried to do that has not helped: _____

What makes the problem worse? ❑Standing ❑Sitting ❑Lying ❑Bending ❑Lifting ❑Twisting ❑Driving

❑Sleep ❑Sports ❑Walking ❑Other _____

Are you pregnant or is there any possibility you may be pregnant? ❑Yes ❑No ❑Uncertain

List any major accidents you have had other than those mentioned above: _____

_____

Remarks/anything else you want the doctor to know: _____

_____

Doctor's Signature: _____ Date: _____

Patient Name: _____

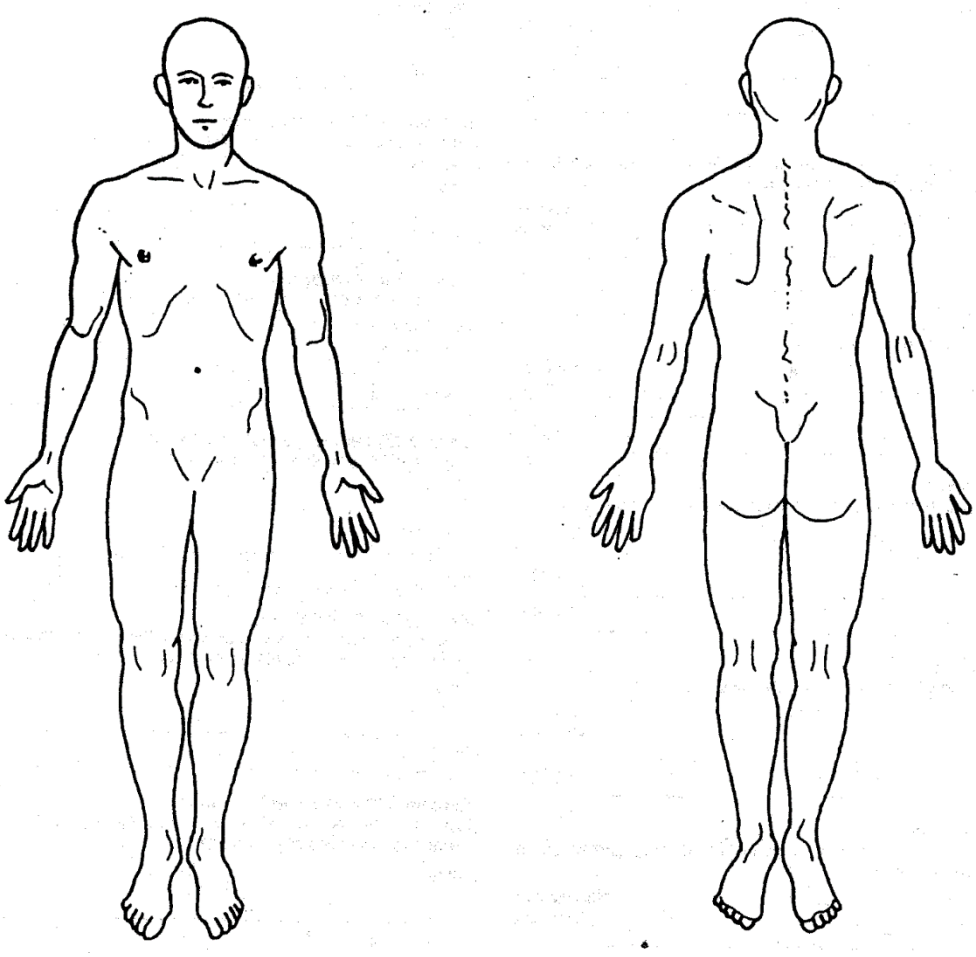
Date: _____

Ivey O'Sullivan Healthcare Services, PA
Dr. Gabriel O'Sullivan, DC
Dr. Stacy Gantt, DC
Dr. Suzzanne Candelaria-Perez, DC
Dr. Michael Neal Quinn, DC
201 S Dean Street, Spartanburg, SC 29302
P: 864.583.3967 F: 864.585.5554

Pain Drawing

Circle the areas on your body where you feel your pain. Include all affected areas. Number the circled areas by which type of pain you feel. Mark areas of radiation by drawing an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. For example, if you ache in your left shoulder and it radiates down to the elbow, circle the left shoulder and draw an arrow to the elbow and write a "1".

1. Ache 2. Numbness 3. Pins & Needles 4. Burning 5. Stabbing 6. Throbbing



Office Use Only

☐ 1

☐ 4-5

☐ >5

Patient Name: _____

Date: _____

Ivey O'Sullivan Healthcare Services, PA
Dr. Gabriel O'Sullivan, DC
Dr. Stacy Gantt, DC
Dr. Suzzanne Candelaria-Perez, DC
Dr. Michael Neal Quinn, DC
201 S Dean Street, Spartanburg, SC 29302
P: 864.583.3967 F: 864.585.5554

Patient Information

Name		Date of Birth	Home Phone
Mailing Address			
City/State/Zip Code			
Email Address		Would you like to receive appointment reminders via text to this phone number? ❑Yes ❑No	Cell Phone
Age	Race	Social Security #	Marital Status
Occupation		Employer	Work Phone
Employer's Address			
Emergency Contact		Relationship to Patient	
Emergency Contact Phone			
How were you referred to our office?			
Family Medical Doctor		May we have permission to update your medical doctor regarding your care at this office? ❑Yes ❑No	

Insurance Information

Please check any and all insurance coverage that may be applicable in this case:

❑Major Medical ❑Worker's Compensation ❑Medicaid ❑Medicare ❑Auto Accident ❑Medical Savings Account & Flex Plans ❑Other

Name of Primary Insurance Company	Name of Secondary Insurance Company

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans 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 payors, 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 by the practice.

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, 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 benefits cannot be determined until the insurance company receives the 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 any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.

The following person(s) have my permission to receive my personal health information: _____

_____

Patient's Signature: _____ Date: _____

Responsible Party's Signature: _____ Date: _____

Patient Name: _____

Date: _____

Ivey O'Sullivan Healthcare Services, PA
Dr. Gabriel O'Sullivan, DC
Dr. Stacy Gantt, DC
Dr. Suzzanne Candelaria-Perez, DC
Dr. Michael Neal Quinn, DC
201 S Dean Street, Spartanburg, SC 29302
P: 864.583.3967 F: 864.585.5554

Medical History

Date of last physical examination:_____/_____/_____

Do you have a history of stroke or hypertension? ❑Yes ❑No

Have you had any major illnesses, injuries, falls, auto accidents or surgeries, including childbirth? ❑Yes ❑No

If yes, what and when: _____

Have you been treated for any health condition by a physician in the last year? ❑Yes ❑No

If yes, describe:_____

What medications or drugs are you taking?_____

Do you have any allergies to any medications? ❑Yes ❑No

If yes, describe:_____

Do you have any allergies of any kind? ❑Yes ❑No

If yes, describe:_____

Do you have any congenital condition? ❑Yes ❑No

If yes, describe: _____

In general, would you say your overall health right now is: ❑Excellent ❑Very good ❑Good ❑Fair ❑Poor

Please indicate beside each activity whether you engage in it:

OFTEN=O SOMETIMES=S NEVER=N

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use

_____ Drug Use

_____ Tobacco Use

_____ Caffeine

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ High Stress Activity

_____Other: _____

Patient Name: _____

Date: _____

Ivey O'Sullivan Healthcare Services, PA
Dr. Gabriel O'Sullivan, DC
Dr. Stacy Gantt, DC
Dr. Suzzanne Candelaria-Perez, DC
Dr. Michael Neal Quinn, DC
201 S Dean Street, Spartanburg, SC 29302
P: 864.583.3967 F: 864.585.5554

For the following symptoms/conditions please indicate with the letter **N** if you have these conditions now or **P** if you have had these conditions previously.

N = Now P = Previously

_____Headaches (Frequency _____)
_____Neck Pain
_____ Stiff Neck
_____ Sleeping Problems
_____ Back Pain
_____ Nervousness
_____ Tension
_____ Irritability
_____ Chest Pains/Tightness
_____ Dizziness
_____ Shoulder/Neck/Arm Pain
_____ Numbness in Fingers
_____ Numbness in Toes
_____ High Blood Pressure
_____ Difficulty Urinating
_____ Weakness in Extremities
_____ Breathing Problems
_____ Fatigue
_____ Lights Bother Eyes
_____ Ears Ring
_____ Broken Bones/Fractures
_____ Rheumatoid Arthritis
_____ Excessive Bleeding
_____ Osteoarthritis
_____ Pacemaker
_____ Stroke
_____ Ruptures
_____ Eating Disorder
_____ Drug Addiction
_____ Gall Bladder Problems
_____ Other: _____

_____ Loss of Balance
_____ Fainting
_____ Loss of Smell
_____ Loss of Taste
_____Unusual Bowel Patterns
_____ Feet Cold
_____ Hands Cold
_____ Arthritis
_____ Muscle Spasms
_____ Frequent Colds
_____ Fever
_____ Sinus Problems
_____ Diabetes
_____ Indigestion Problems
_____ Joint Pain/Swelling
_____ Menstrual Difficulties
_____ Weight Loss/Gain
_____ Depression
_____ Loss of Memory
_____ Buzzing in Ears
_____ Circulation Problems
_____ Seizures/Epilepsy
_____ Low Blood Pressure
_____ Osteoporosis
_____ Heart Disease
_____ Cancer
_____ Coughing Blood
_____ Alcoholism
_____ HIV Positive
_____ Ulcers

Patient Name: _____

Date: _____

Ivey O'Sullivan Healthcare Services, PA
Dr. Gabriel O'Sullivan, DC
Dr. Stacy Gantt, DC
Dr. Suzzanne Candelaria-Perez, DC
Dr. Michael Neal Quinn, DC
201 S Dean Street, Spartanburg, SC 29302
P: 864.583.3967 F: 864.585.5554

Family Medical History

Indicate those diseases and conditions that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

I certify the information provided is accurate to the best of my knowledge.

Signature of Patient/Legal Guardian _____ Date _____

Patient Name: _____

Date: _____

Ivey O'Sullivan Healthcare Services, PA
Dr. Gabriel O'Sullivan, DC
Dr. Stacy Gantt, DC
Dr. Suzzanne Candelaria-Perez, DC
Dr. Michael Neal Quinn, DC
201 S Dean Street, Spartanburg, SC 29302
P: 864.583.3967 F: 864.585.5554

Informed Consent

Consent to Chiropractic Treatment

Please read this entire section regarding chiropractic care prior to accepting it. It is important that you understand the information contained in this section. Please ask questions before you accept it if there is anything that is unclear.

- **The nature of the chiropractic analysis and treatment**

The primary treatment that is performed by a Doctor of Chiropractic is spinal manipulative therapy. This clinic may use that procedure to treat you. This may include the use of the hands or a mechanical instrument upon your body in such a way as restore normal joint motion. It may cause an audible 'pop' or 'click,' much as you have experienced when you 'crack' your knuckles. You may feel a sense of movement.

- **Analysis/ Examination / Treatment**

As a part of the analysis, examination, and treatment, the doctor may want to employ a variety of procedures as may be deemed necessary. These procedures include but are not limited to:
Spinal manipulative therapy, chiropractic adjustments, vital signs, range of motion testing, palpation, orthopedic testing, basic neurological testing, postural analysis testing, muscle strength testing, radiographic studies, scanning of feet, EMS, exercises, acupuncture, myofascial treatments, hot/cold therapy, mechanical traction, traction/decompression, laser therapy, vibrational pivot platform, or cranial balloon adjustments (CFR).
By accepting this document you are consenting to these procedures as recommended/prescribed by this clinic.

- **The material risks inherent in chiropractic adjustment.**

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation or from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an 'arterial dissection' that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

- **The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which the provider will check during the taking of your history during examination and X-ray. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admissions attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons and the risk of death has been estimated at 140 per one million users.

- **The availability and nature of other treatment options.**

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics & rest
- Medical care & prescription drugs
- Hospitalization
- Surgery

If you choose to use one of the above noted other treatment options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

- **The risks and dangers to remaining untreated.**

Remaining untreated may allow the formulation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed with the clinic any questions and concerns I have and they have been answered to my satisfaction. By accepting, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Printed Name _____ Signature of Parent/Guardian _____

Signature _____ Date _____

Patient Name: _____

Date: _____

Ivey O'Sullivan Healthcare Services, PA
Dr. Gabriel O'Sullivan, DC
Dr. Stacy Gantt, DC
Dr. Suzzanne Candelaria-Perez, DC
Dr. Michael Neal Quinn, DC
201 S Dean Street, Spartanburg, SC 29302
P: 864.583.3967 F: 864.585.5554

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy **before receiving services**. For more information about Health Information Portability and Accountability Act (HIPAA) and health information privacy visit: http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

- The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
- The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
- The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
- This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
- Patients have the right to file a formal complaint with our privacy official about any suspected violations.
- This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

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 this practice and acknowledge that certain risks 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 and assigns benefits to be paid directly to that professional by my third-party payor.

Initial _____

Printed Name _____ Signature of Parent/Guardian _____

Signature _____ Date _____