PATIENT REGISTRATION FORM

Patient Information

First name: _______________ M.I.: _______ Last name: _______________

Social security number: _______________

Address: _______________

City: _______________ State: _______ Zip code: _______________

Primary phone: ( ) _______________ Email

address: _______________

Date of birth: ____ / ____ / ____

Sex: (circle one) Male Female Other

Marital status: (circle one) Single Married Divorced Widowed

Employer: _______________

Address: _______________ State: _______ Zip code: _______________

Telephone: ( ) _______________

Work status: (circle one) Full Part-time Retired Student: (circle one) Full Part-time

Guarantor (*responsible party, spouse, or guardian)*: _______________

Children *(names and ages)*: _______________

Payment and Insurance Information

Primary insurance: _______________

Address: _______________

City: _______________ State: _______ Zip code: _______________

Telephone: ( ) _______________

Type: (circle one) Individual Group Medicaid Blue Cross Blue Shield

Group name: _______________ Group/Plan #: _______________

ID #: _______________

Policy holder: _______________

Date of birth: ____ / ____ / ____

Relationship to patient: _______________

Other insurance: _______________

Address: _______________

City: _______________ State: _______ Zip code: _______________

Continued on back →

Telephone: ( ) _______________

Type: (circle one) Individual Group Medicaid Blue Cross Blue Shield

Group name: ______________________ Group/Plan #: ______________________

ID #: ______________________

Policy holder: ______________________

Date of birth: ____/____/________

Relationship to patient: ______________________

Patient/Responsible Party: ______________________

Date signed: ____/____/________

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice of Privacy describes how we may use and disclose your Protected Health Information (PHI) to carry our treatment payment or Health Care Operations (TPO) for other purposes that are permitted or required by law. “Protected Health Information” is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for insurance coverage.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of an appointment.

We may use or disclose your protected health information in the following situations without your authorization: as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in this authorization.

Patient name printed: ______________________ Patient signature: ______________________

Date: ____/________/________

OFFICE USE ONLY:

IDC-10 codes: ______________________

First treatment date (Medicare): ______________________

X-Ray date or PART: ______________________

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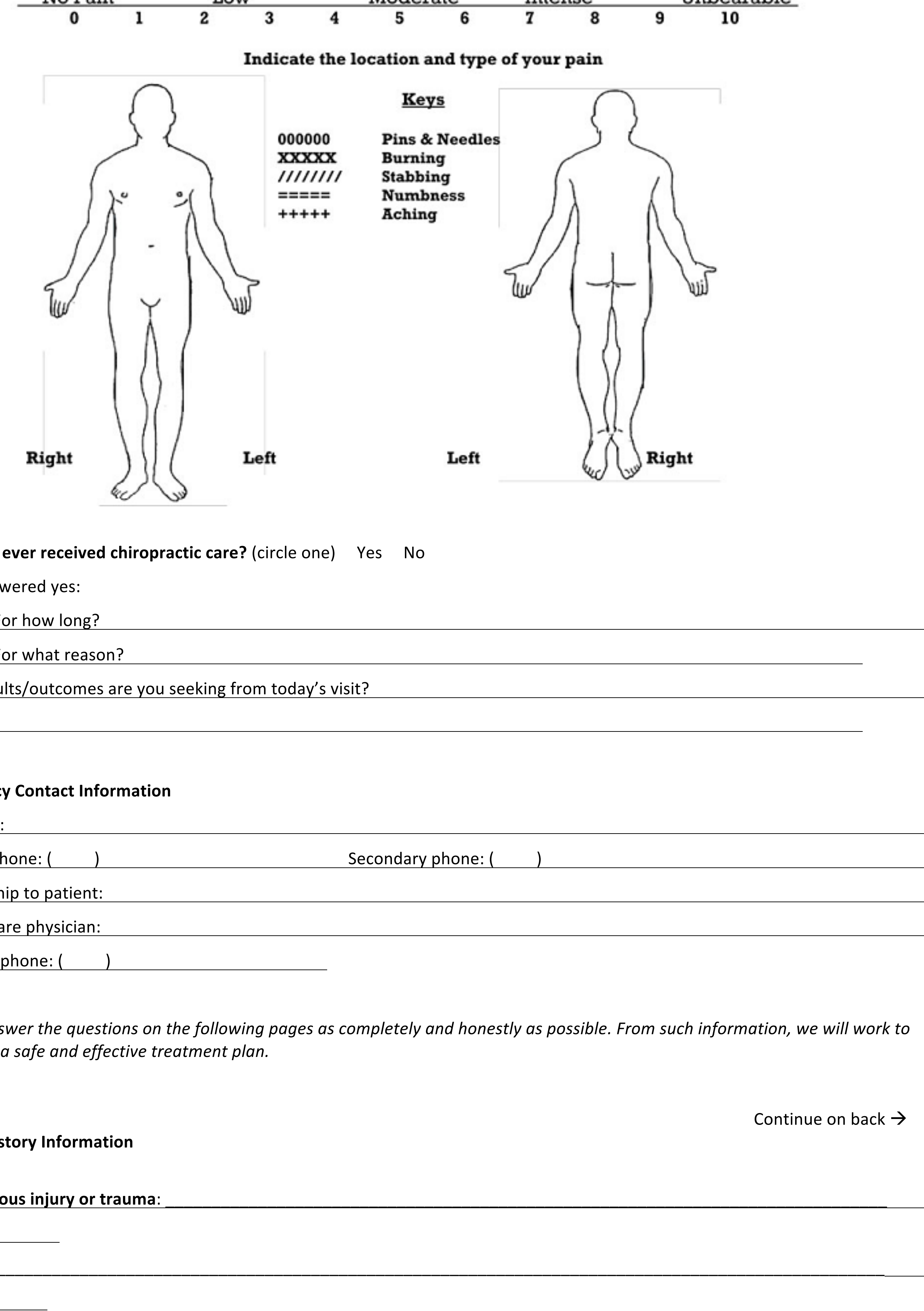
PATIENT HEALTH INTAKE FORM



No Pain			Low			Moderate		Intense		Unbearable
0	1	2	3	4	5	6	7	8	9	10

Indicate the location and type of your pain

Keys

000000	Pins & Needles
XXXXX	Burning
////////	Stabbing
=====	Numbness
+++++	Aching

Right Left Left Right

Have you ever received chiropractic care? (circle one) Yes No

If you answered yes:

For how long? ______________________________

For what reason? ______________________________

What results/outcomes are you seeking from today's visit? ______________________________

____

Emergency Contact Information

Full name: ______________________________

Primary phone: (   ) ______________ Secondary phone: (   ) ______________

Relationship to patient: ______________________________

Primary care physician: ______________________________

Physician phone: (   ) ______________

Please answer the questions on the following pages as completely and honestly as possible. From such information, we will work to construct a safe and effective treatment plan.

Continue on back →

Health History Information

1. **Previous injury or trauma**: ______________________________

____

a. If you have broken any bones, which have you broken? ____________________

2. **Allergies**:

____

____

3. **Medication** (*if unsure of the name, please write what it is for*): ____________________

____

a. Vitamins and/or supplements? ____________________

4. **Surgeries or procedures**

a. Type of surgery/procedure: ____________________

____

b. Date(s) undergone: ____________________

5. **For Females Only**

a. Are you pregnant? (circle one) Yes No

b. If yes, how far along?

____

c. If no, are you try to conceive?

____

d. Do you have a history of miscarriage?

____

6. **Family health history**

a. Do you have a family history of: (circle those that apply)

Cancer Stroke/TIA's Headaches Cardiac disease Neurological diseases Psychiatric disease

Adopted/unknown Cardiac disease under 40 Diabetes Other: ____________________

b. Cause of death, and age at death, of immediate family members: ____________________

____

7. **Social and stress-related history**

a. Recreational activities: ____________________

____

b. Lifestyle (hobbies, exercise, alcohol, tobacco, drug use, diet, etc.): ____________________

c. Have you ever smoked? How long have you smoked for, and how often?

d. General stress level: (circle one) Very high High Moderate Mild Low No stress

e. Primary source of stress:

f. What stress-reduction activities are you participating in?

Please add any information you believe we should know, in order to help you to the best of our ability:

Continue on next page →

Circle all that apply as symptoms that you are CURRENTLY experiencing.

MUSCULOSKELETAL	**NEUROLOGICAL**	**EYES/EARS/NOSE/THROAT**	**DERMATOLOGICAL**
Low back pain Mid back pain Neck pain Arm problems Leg problems Painful joints Stiff/swollen joints Sore/weak muscles or joints Muscle spasms/cramps Rheumatoid arthritis Gout Osteoarthritis Broken bones Spinal fracture Arthritis (unknown type) Scoliosis Metal implants	Numbness or tingling Loss of feeling Dizziness or light headed Vertigo Frequent headaches Convulsions or seizures Tremors Stroke Head injury Car accident Visual changes/loss of vision One-sided weakness of face/body One-sided decreased feeling in face/body Loss of sense of smell	Contacts/glasses Blurred or double vision Glaucoma Eye disease or injury Bleeding gums/mouth sores Bad breath/taste in mouth swollen throat/voice change Ringing in ears Ear-ache or drainage Sinus/allergy problems Nose bleeds Hearing loss	Dry skin Rash or itching Change in hair or nails Non-healing sores Change in mole appearance Boils Significant burns Skin grafts Psoriatic disorders
GASTROINTESTINAL	**CARDIOVASCULAR/HEART**	**RESPIRATORY**	**PSYCHOLOGICAL**
Loss of appetite Blood in stool Change in bowel movements Painful bowel movements Nausea/vomiting Abdominal pain Frequent diarrhea Constipation Difficulty swallowing Ulcerative disease Hepatitis, pancreatic or liver disease Reflux or heartburn	Angina/chest pains Rapid or heartbeat changes Hypertension Hypotension Swelling of hands/ankles/feet Heart disease/problems Congestive heart failure Murmurs or valve disorders Heart attacks/MI Pacemaker	Difficulty breathing Persistent cough Asthma or wheezing Lung problems COPD Emphysema	Nervousness Depression Sleep problems Memory loss or confusion Psychiatric diagnosis Suicidal ideations Bipolar disorder Homicidal ideations Schizophrenia Psychiatric hospitalizations
ENDOCRINE/HORMONES	**HEMATOLOGICAL/BLOOD**	**URINARY**	**OTHER**
Swollen glands Thyroid problems Diabetes Cold extremities Heat/cold intolerance Glandular or hormone problem Hormone replacement therapy Injectable steroid replacements	Anemia Easily bruise or bleed Phlebitis Transfusion Varicose veins Regular anti-inflammatory use Regular aspirin HIV positive Sickle-cell anemia	Kidney stones Burning/painful urination Change force of urination Frequent urination Blood in urine Incontinence/bed-wetting Bladder infections Kidney disease Dialysis	Bacterial infection Viral infection Fever Fatigue Recent change in weight Lowered immune function High levels of stress

	Enlarged lymph nodes Hemophilia Blood clots or DVT Anti-coagulant therapy		

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby consent to the performance of chiropractic procedures.

Patient name: ______________________ Patient signature: ______________________

Date: ______ / ______ / ______

Continued on back →

PATIENT INFORMED CONSENT FORM

You will sign this after speaking about your treatment options with the doctor.

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or the patient named below for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now, or in the future, treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure.

I further understand and I am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants, and pain killers; physical therapy, steroid injections, bracing, and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient name printed: ______________________ Patient signature: ______________________

Date: ______ / ______ / ______

Printed name of Guardian: ______________________ Guardian signature: ______________________

Relationship to patient: ______________________

Date: ______ / ______ / ______

Chiropractor name: ______________________ Chiropractor signature: ______________________

Date: ______ / ______ / ______