CHIROPRACTIC REGISTRATION & HISTORY

PATIENT INFORMATION

Date _____

Nickname _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Additional Health History

Sleep: _____ hours/night

Do you sleep on your: __ Back __Side __Stomach

Type of pillow used? __Thick __Medium __Thin __None __Support

Age of mattress/waterbed? _____

Do you consider your bed comfortable? __Yes __No

Do you wear... __Heel Lifts __Shoe Lifts __Arch Supports __Orthotics

Non-Job Exercise: ____ hours/week
Type of exercise: _____

Typical Diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____

Appointment Cancellation Policy

Because we respect your time, our office attempts to run on schedule. Please assist us in reaching this goal by arriving timely for your appointments. Thank you.

A missed appointment fee of $40 will be charged for any visit that is not cancelled within 24 hours prior to scheduled time.

Patient Signature _____

PHONE NUMBERS

Home Phone (____) _____ Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

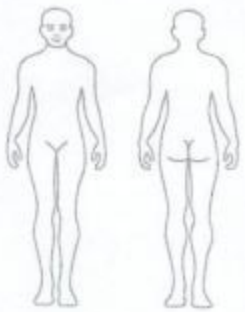
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

Pharmacy Name _____

Pharmacy Phone (____)_____

Review of Systems: Please indicate any personal history below:

☐ **Constitutional Symptoms**

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

☐ **Eyes**

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes

☐ **Ears/Nose/Mouth/Throat**

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

☐ **Cardiovascular**

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath w/walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

☐ **Respiratory**

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

☐ **Gastrointestinal**

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain	No	Yes

☐ **Genitourinary**

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male - testicle pain	No	Yes
Female - pain with periods	No	Yes
Female - irregular periods	No	Yes
Female - vaginal discharge	No	Yes
Female - # of pregnancies	_____	
Female - # of miscarriages	_____	
Female - date of last pap smear	_____	

☐ **Musculoskeletal**

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

☐ **Integumentary (skin, breast)**

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

☐ **Neurological**

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Head injury	No	Yes

☐ **Psychiatric**

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

☐ **Endocrine**

Glandular or hormone problem	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

☐ **Hematologic/Lymphatic**

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Novocain or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, Merthiolate or other antiseptic	No	Yes

Other drugs/medications: _____

Known food allergies: _____

Environmental allergies: _____

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE	☐		☐		☐	
DECEASED	☐		☐		☐	
BROTHERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
SISTERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
CHILDREN	NO. ALIVE	AGES & HEALTH		NO. DECEASED	AGES & CAUSE OF DEATH	

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES: ☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis ☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibilty to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent or Guardian _____ Date _____

Doctor's Review

Signature of Doctor _____ Date _____

FINANCIAL AGREEMENT

To assist our patients in the health care insurance process, we have designed the following. Please read carefully.

IT IS OUR OFFICE POLICY TO COLLECT CHARGES FOR SERVICES AS THEY ARE RENDERED. PLEASE READ AND INITIAL THOSE SELECTIONS BELOW THAT PERTAIN TO YOU (MARKED WITH AN X).

_____1. Health Insurance – If the charges for services are covered by insurance, we will submit a claim for benefits upon receipt of the necessary information from the patient. As per office policy, the patient will be required to pay for services at the time they are rendered and the insurance company will be instructed to send its reimbursement directly to the patient.

_____2. Medicare – Medicare pays for 80% of the chiropractic adjustment if it is deemed medically necessary. As per Medicare policy, after you submit proof of meeting your yearly deductible, we will accept the 20% copay if you do not have secondary insurance. If you have secondary insurance, upon receiving our first check from your secondary insurance carrier, we will not require that you pay the 20% copay. See sheet titled "About Medicare Coverage".

_____ I hereby assign the benefits that I am eligible to receive for the care rendered in the office to this office. In consideration of this assignment the office will extend credit. Any balance due will be paid immediately upon receipt of the statement.

_____3. Private Pay – The patient has no insurance and is responsible for all health care costs.

AUTHORIZATION STATEMENT

_____ I authorize the office to release any information to any insurance company, adjuster, or attorney that will assist in the payment of a claim.

_____ I fully understand and agree that insurance policies are an arrangement between the insurance carrier and myself. I will be responsible for any expenses not paid by insurance.

A photocopy of this form shall be valid as the original.

_____ _____

Date Patient (or Parent/Guardian)

Edie Spence, D.C.

284 Hill Street
Murphy, North Carolina 28906
Chiropractic, Nutrition, Acupuncture and Oriental Herbs
Tel: 828-837-1821

CONSENT TO CHIROPRACTIC SERVICES

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic who now or in the future treats me while employed by, working or associated with or serving as a backup for the Doctor of Chiropractic named above, including those working at the clinic or office listed above.

I have had an opportunity to discuss with the Doctor of Chiropractic named above and / or with other office or clinic personnel the scope of practice, nature and purpose of chiropractic care: specifically, manual care; adjustments, and other procedures. I understand that with manual care, i.e., adjustments, there is a certain risk of but not all inclusion of: muscle or ligament strains or sprains, bony fractures, cerebral vascular or neurological insult.

I understand and am informed as to the nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to me by the above-named Doctor of Chiropractic and/ or his/her associates and assistants. I do not expect the Doctor to be able to anticipate and explain all the risks and complications and wish to rely on the Doctor to exercise judgment during the course of the procedure which the Doctor feels at the time, based upon the facts then known, is in my best interests.

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

_____

Print Patient's Name

Date

_____

Signature of Patient

Date

_____

Witness / Relationship to Patient

Edie Spence, D.C.

284 Hill Street
Murphy, North Carolina 28906
Chiropractic, Nutrition, Acupuncture and Oriental Herbs
828-837-1821

INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures, including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the physician or other licensed physician who now or in the future treats me while employed by, working or associated with or serving as a backup for the physician named above, including those working at this clinic or office.

I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese or Western herbal medicine and nutritional counseling. I have had an opportunity to discuss with the physician named above and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising, tingling, or soreness near the needling sites that last a few days. There have been very rare instances reported of fainting, infection, and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that may be recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the physician.

I do not expect the physician to be able to anticipate and explain all risks and complication. I wish to rely on the physician to exercise judgment during the course of the procedure, which the physician feels at the time, based upon the facts then known, is in my best interest.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____
Print Patient's Name

Date
_____
Signature of Patient (or Parent/Guardian)

Date
_____
Witness / Relationship to Patient