Chiropractic Registration and History

Patient Information

Date _____

Patient Name _____

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Spouse Name _____

Birthdate _____ SS# _____

Occupation _____

Employer _____

Whom may we thank for referring you?

_____

Phone Numbers

Home _____ Work _____ ext. ____

Best time and place to reach you _____

In Case of Emergency, Contact

Name _____

Relationship _____

Home _____ Work _____ ext. ____

Patient Information

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Henderson Chiropractic & Sports Rehab, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I certify that the information on this sheet is correct to the best of my knowledge.

_____

Patient / Responsible Party Signature

_____ _____

Relationship Date

Email Address Information

Please check one of the following:

( ) email monthly newsletters/appointment reminders

( ) email outstanding bills/balances to me

( ) I do not have an email/do not email me

Email address:

_____

Patient Condition

Reason for Visit _____

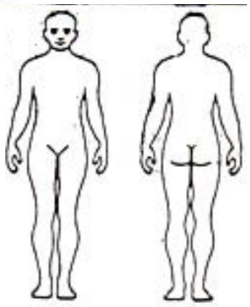
When did your symptoms/complaints appear? _____

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

Rate the severity of your pain on a scale from 0 (no pain) to 10 (severe pain)

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting

Mark an X on the picture where you have pain, numbness, tingling, etc.



How often do you have this problem? ☐1 x daily ☐2 or more x daily ☐1 x weekly ☐2 or more x weekly ☐Other _____

Is it : ☐Constant ☐Come and go ☐Other _____

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(s) have you already received for your present condition(s)? If any, please list below

☐None ☐Medications ☐Chiropractic ☐Physical Therapy ☐Surgery ☐ Other _____

Injuries/Surgeries/Treatments you have had: Description Date

Medications _____

Chiropractic Treatment _____

Physical Therapy _____

Surgeries _____

Other _____

Previous Injuries History	Vitamins/Herbs/Minerals You Take	Allergies
Falls _____	_____	_____
Broken Bones _____	_____	_____
Dislocations _____	_____	_____
Head Injuries _____	_____	_____

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

_____

Date of Last:

Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

MRI / CT / Bone Scan _____ For What Reason _____

Place a mark either "YES" or "NO" to indicate if you have had any of the following:

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

Exercises	**Work Activity**	**Habits**	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day _____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason _____

Females Only Are you pregnant? ☐YES ☐NO Due Date: _____

Patient's Name _____

Neuropathy Pain Scale

The following scales have been designed to find out about your complaint and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Please use the scale below to tell us how intense your pain is:

No Pain — Most Intense Pain Possible

0 1 2 3 4 5 6 7 8 9 10

2. Please use the scale below to tell us how sharp your pain feels. Words used to describe "sharp" feelings include "like a knife," "like a spike," "jabbing" or like "jolts."

Not Sharp — The most sharp pain imaginable

0 1 2 3 4 5 6 7 8 9 10

3. Please use the scale below to tell us how hot your pain feels. Words used to described very hot pain include "burning and "on fire."

Not Hot — The most hot sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

4. Please use the scale below to tell us how dull your pain is. Words used to describe very dull pain include "like a dull toothache," "dull pain," "aching," and "like a bruise."

Not Dull — The most dull sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

5. Please use the scale below to tell us how cold your pain feels. Words used to describe very cold pain include "like ice" and "freezing."

Not Cold — The most cold sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

6. Please use the scale below to tell us how sensitive your skin is to light touch or clothing. Words used to describe sensitive skin include "like sunburned skin" and "raw skin."

Not sensitive — The most sensitive sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

7. Please use the scale below to tell us how itchy your pain feels. Words used to describe itchy pain include "like poison oak" and "like a mosquito bite."

Not Itchy — The most itchy sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

8. Now that you have told us the different physical aspects of your pain, the different types of sensations, we want you to tell us overall how unpleasant your pain is to you. Words used to describe very unpleasant pain include "miserable" and "intolerable." Remember, pain can have a low intensity, but still feel extremely unpleasant, and some kinds of pain can have a high intensity but be very tolerable. With this scale, please tell us how unpleasant your pain feels.

Not Unpleasant at All — The most unpleasant sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

9. We want you to give us an estimate of the severity of your deep versus surface pain. We want you to rate each location of pain separately. We realize that it can be difficult to make these estimations, and most likely it will be a "best guess," but please give us your best estimate.

How intsense is your deep pain?

No Deep Pain — The most intense deep pain sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

How intense is your surface pain?

No Surface Pain — The most intense surface pain sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

10. Which of the following best describes the time quality of your pain? Please check only one answer.

☐ I feel a back ground pain all of the time and occasional flare-ups (break-through pain) some of the time.
Describe the background pain: _____
Describe the flare-up (break-through pain): _____

☐ I feel a single type of pain all the time - Describe this pain: _____

☐ I feel a single type of pain only sometimes- Other times, I am pain free.
Describe this occasional pain: _____

Print Patient Name: _____ Patient Signature: _____ Date: _____

Neuropathy Pain scale: From Galer BS, Jensen MP. Development and preliminary validation of pain measure specific to Neuropathic pain: The Neuropathic pain scale. Neurology. 1997;48(1):332-338. Reprinted with permission from Lippincott Williams & Wilkins.

Authorization to Release Medical Information

I am authorizing the following person(s) to have access to my medical records

_____ _____ (relationship)

_____ _____ (relationship)

_____ _____ (relationship)

☐ None: _____

Patient Signature: _____ Date: _____

Authorization to Contact Patient

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of to the individual's home

I wish to be contacted in the following manner (check all that apply)

____ Home Telephone _____
- ____ Okay to leave message with detailed information
- ____ Leave message with call-back number only
- ____ Leave appointment reminder information

____ Work Telephone _____
- ____ Okay to leave message with detailed information
- ____ Leave message with call-back number only
- ____ Leave appointment reminder information

____ Written Communication
- ____ Okay to mail to my home address
- ____ Okay to mail to my home or work address
- ____ Okay to fax to this number

_____

____ Other
- ____ Okay to to leave a message on this cell number

_____

The Practice's Privacy Notice has been provided to me prior to my signing below. I have had a chance to ask questions and/or have concerns addressed. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that a copy of the Privacy Notice prior to signing this Consent, and had encouraged me to read the Privacy Notice carefully prior to my signing this consent. I understand that this consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me. I have read and understand the above statements, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Your Physician is not required to agree to a restriction that you may request. If your physician believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If this is a conflict for you, you have the right to use another Healthcare Professional.

Patient Signature: _____ Date: _____

Permission to receive information regarding your services.
Please check all that apply.

☐ Home Phone: _____

☐ Cell Phone Number: _____

☐ Work Phone: _____

Carrier: _____

****Message and data rates may apply****

☐ Email: _____

Signature: _____ Date _____

Henderson Chiropractic and Sports Rehab Clinic

Our Office Policy on Insurance Assignment

Our office is pleased to accept your insurance assignment, subject to verification of your exact coverage. We will file your claim forms and assist you in every way we can. However, the insurance contract is between you and your insurance company, and you are fully responsible for **any** non-covered amount.

Office Policy Regarding Insurance Assignment

1. This office **does not** guarantee your insurance company will pay for your care. By accepting assignment, we must wait for payment. This courtesy may be withdrawn if circumstances warrant.

2. If we are able to verify and accept insurance, we will bill your insurance periodically as long as you are a patient of this office. Should your insurance company terminate coverage or disallow all or a portion of the claim for any reason, you remain responsible for your outstanding balance. All charges incurred at **Henderson Chiropractic and Sports Rehab, P.C.** are your total responsibility regardless of payment by you, your insurance company, or other person's responsible for your account, and regardless of satisfaction of care. A payment plan can be set up with our business manager.

3. You are always responsible for the entire uninsured balance of your account. Discontinuance of care does not relieve you of your responsibility to pay for services already rendered. **If Payment From Insurance Company Is Not Received Within 60 Days Of Service, The Patient (You) Will Receive A Billing Statement And Is Expected To Pay For Services In Full Within 7 Business Days Of The Statement Date or a finance charge will be added to your account.** To find out the current finance charge of our office feel free to consult with the front desk. Should an overpayment be received, any credit balance will be cheerfully and expeditiously refunded.

4. To avoid large balances, you must pay your deductible and co-insurance portion **as you go** unless a prior arrangement has been made. Our office will not enter into a dispute with your insurance company over a claim. This is your responsibility and obligation.

5. If this account is placed with an attorney or collection agency for collection, **be advised that additional fees may be added**. If litigation pursues, you also understand you will be responsible for additional court cost or attorney fees.

6. If you understand and agree to these policies, please sign your name below. We will accept your insurance assignment, subject to verification. This office will answer questions and complete requests for additional information received from your insurance company.

Print Patient's Name: _____

Patient's Signature: _____Date:_____

Patient's Representative Signature:_____Date:_____

Henderson Chiropractic & Sports Rehab, P.C.

INFORMED CONSENT TO CHIROPRACTIC TREATMENTS AND CARE

I hereby request and consent to the performance of Chiropractic treatments and other Chiropractic procedures, including various modes of physical modalities and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor/employees of Henderson Chiropractic and Sports Rehab, P.C. and/or any licensed Doctor of Chiropractic who now or in the future treat me while employed by, working for, or associated with, or serving as back-up for the Doctor of Chiropractic employed by Henderson Chiropractic and Sports Rehab, P.C., whether it be this location or a satellite clinic. I have had an opportunity to discuss with Dr. Henderson and/or with other office personnel the nature and purpose of Chiropractic treatments and other procedures. I understand that results are not guaranteed.

I understand and am informed that in the practice of Chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains, and these are rarely encountered. I do not expect the Doctor to be able to anticipate and explain all risks and complications. I wish to rely on the Doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interest. 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 form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

All charges incurred at **Henderson Chiropractic & Sports Rehab Clinic P.C.** are my total responsibility regardless of payment by me, my insurance company, or other person's responsible for my account, and regardless of satisfaction of care. If this account is placed with an attorney or collections agency for collection, I am aware of having additional fees added. If litigation pursues, I also understand I will be responsible for additional court cost or attorney fees.

Patient's Signature: _____ Date: _____

Patient's Representative's Signature: _____

Henderson Chiropractic & Sports Rehab, P.C.

ABOUT YOUR CARE

Chiropractic provides three types of care:

Initial Intensive Care: This includes relief and symptomatic care. The goal is to eliminate or reduce your major complaints as well as stabilize your condition(s). This requires frequent visits (several times per week) that may continue for weeks to months.

Rehabilitative Care: This rehabilitative care is designed to provide optimum healing of the function(s) of the spine, associate tissues and organ systems. This helps prevent the original problem from returning. Frequency of visits varies, but it is less than Initial Intensive Care.

Wellness/Maintenance Care: This is designed to maintain your improved health and spinal function. The decision to begin this care is made once it is determined your condition(s) have recovered the best it can from the possible permanent damage that may have occurred prior to care. Visit frequency is based on the needs of the individual and is less than Rehabilitative Care.

*All of these options will be explained at your **Report of Findings**, and then you will be able to begin a course of care that best fits your health goals.*

Questions: Do not hesitate to ask questions, we want you to be informed. Proper communication is an absolute necessity. Our primary concern is to help you attain your optimum health.

Acknowledgment: I have read and fully understand the above statements.

Patient's Signature: _____ Date: _____

Patient's Representative's Signature: _____