PATIENT REGISTRATION

Patient Name____Today's Date_______________________________________

SSN____________________________**Birth Date**______________________**Age**_________**Sex** Male Female

I am □ a Minor □ Married □ Single □ Divorced

EMAIL____

Address____**City**_____________________**State**_________**Zip**__________________________

Home Phone_______________________**Cell Phone**________________________

Work Phone___________________________________**Is it okay to contact you at work?** Y or N

Employer____**Occupation/School**____

Work activity □ Sit □ Stand □ Light Labor □ Heavy Labor Other____

Who referred you to our office? ____

Who is responsible for payment □Self □Spouse □Parent □Other ____

Insurance Company #1______________________________ **#2**____

Condition is due to □ Auto Accident □ Work Injury □ Home □Other____

COMMUNICATIONS

Would you like appointment reminders by □Text □ Email □ No Reminder Necessary

Cell Phone Carrier (i.e. AT&T, Sprint, Verizon) ____

In the event that we would need to communicate your healthcare information, to whom may we do so?

□ Spouse _____________________________ □Children____

□ Other _____________________________ □ No one

443 West Loveland Avenue ●Loveland, Ohio 45140 ● Phone 513-683-2225 ● Fax 513-683-1225

PATIENT CASE HISTORY

Reason for appointment____

Describe Major Complaint____

Began When? ___/___/____ **Describe how this began**:____

Grade Intensity/Severity of Complaint: None/Mild/Moderate/Severe/Very Severe

Quality of the complaint/pain: Sharp/Stabbing/Burning/Achy/Dull/Stiff & Sore/Other:___________________________________

How frequent is the complaint present: Off & On/ Constant

Does this complaint radiate/shoot to any areas of the body? No/ Yes (Describe)_____________________________________
Head- Base of Skull/ Forehead/ Side-Temple R/ L/ Both *Leg*- Hip/ Thigh- Knee/ Calf/ Foot-Toes R/ L/ Both
Arm- Across Shoulder/ Elbow/ Hand- Fingers R/ L/ Both *Other Area:* ____

Symptoms worse □ Morning □ Afternoon □ Night □ Increase During Day □ Same All Day □ Decrease During Day □ Varies

Tried relieving symptoms with □ Heat □ Ice □ Rest □ Stretching □ OTC □ Modified/ Stopped Activity □ Other ____________________

Does anything make the complaint better? Ice/ Heat/ Movement/ Stretching/ OTC/ Other_________________________________

Does anything make the complaint worse? Sit/ Stand/ Walk/ Lying/ Sleep/ Overuse/ Other: ______________________________

Which daily activities are being affected by this condition? (Describe)____

For this CURRENT condition, have you:

- Received any other treatment? None/ DC/ MD/ PT/ Massage/ ER/ Other: ____________Where? ____________________________
- Had any Medications? OTC/ Prescriptions ____
- Had any diagnostic testing? X-ways/ MRI/ CT/ Other: _______________When and Where? _____________________________

Describe Any Secondary Complaints: ____

Have you been treated for any health condition in the last year? □No □ Yes, explain ___________________________________

HEALTH QUESTIONNAIRE

Patient____Date____

PLEASE MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING.

Musculoskeletal System
- ☐ Low back pain/stiffness
- ☐ Mid back pain/stiffness
- ☐ Pain between shoulders
- ☐ Neck pain/stiffness
- ☐ Shoulder problems
- ☐ Arm//Elbow problems
- ☐ Wrist/Hand problems
- ☐ Leg/Hip/Knee problems
- ☐ Ankle/Foot problems
- ☐ Painful joints
- ☐ Stiff/Swollen joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Muscle spasms
- ☐ Loss of motion/movement
- ☐ ________________________

Eye & Ear
- ☐ Eye infection / inflammation
- ☐ Vision problems
- ☐ Ear pain / discharge
- ☐ Hearing loss/noises/ringing

Genitourinary System
- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Prostate problems

Female ONLY
- ☐ Hormonal problems
- ☐ Breast problems
- ☐ Reproductive problems

Are you PREGNANT ?
☐ **YES** ☐ **NO**
Due Date_______________

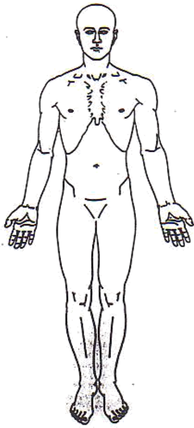
Habits
- ☐ Smoking ____________pk/day
- ☐ Caffeine drinks ______cups/day
- ☐ Alcohol __________drinks/day
- ☐ High Stress level
  reason________________

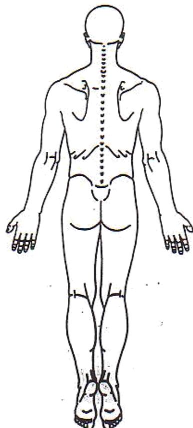
Gastrointestinal System
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver problems
- ☐ Gallbladder problems
- ☐ Weight trouble/changes

Nose & Throat
- ☐ Nose pain/bleed/discharge
- ☐ Mouth/throat sore/hoarse
- ☐ Jaw / mouth problems
- ☐ Sinus problems

Nervous System
- ☐ Headaches
- ☐ Numbness
- ☐ Tingling
- ☐ Loss of feeling
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

Cardiovascular & Respiratory
- ☐ Chest / heart pain
- ☐ Varicose veins
- ☐ Heart problems
- ☐ Hard to breathe
- ☐ Lung problems





Circle area(s) of complaint.

Family History: M = me F = family

- ☐ Arthritis ______
- ☐ Diabetes ______
- ☐ High Blood Pressure ______
- ☐ Cancer ______
- ☐ Epilepsy ______
- ☐ Heart Attack ______
- ☐ Stroke ______
- ☐ Tuberculosis ______
- ☐ Concussion ______
- ☐ Asthma ______

☐ None Apply

Allergies: ☐ None ____

Medications: ☐ None ____

____

Vitamins: ☐ None ____

Exercise: ☐ None ☐ Daily ☐ _______ times/Week ☐ Recreational/Wknds only Other________________________________

List Injuries / Surgeries you have had with dates: **My Medical Doctor (PCP) is** ______________________________

Falls: ☐ None ____

Head injuries: ☐ None ____

Broken bones: ☐ None ____

Surgeries: ☐ None ____

Other health conditions you presently suffer from: ☐ None ____

Patient____ Date______________________________

HIPAA – Privacy of your Patient Health Information (PHI): 11/14
Before we will begin any health care operations we require you to read this consent form stating that you understand and agree with how your records will be used. If you would like a more detailed explanation of our policies and procedures regarding your Patient Health Information (PHI) we encourage you to read or take the HIPAA NOTICE available to you at the front desk before signing this consent. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. For your security and right to privacy, all staff are trained in patient record privacy procedures and a privacy official has been designated to enforce those procedures in our office. Patients have a right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

X-RAYS FROM THIS OFFICE ARE SENT OUT TO BE READ BY AN X-RAY RADIOLOGIST:
I understand that in the event x-rays are taken, that the services of a qualified radiologist from *Diagnostic Imaging, Inc.* may be utilized for a second opinion or further interpret my x-rays and give consent for their release. I understand that there will be a **$25 fee for this service which is separate from and in addition to that of the chiropractic clinic fees.**

PROFESSIONAL SERVICES CONSENT, RELEASE OF INFORMATION & INSURANCE INFORMATION:
I authorize the assignment of insurance benefits to the chiropractor or chiropractic office. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. I understand I may receive a billing statement for: insurance denial, professional fees that have been applied to my deductible, co-payments, or any balance due stated by the insurance company as my responsibility. In the event that I receive payment for any services I agree to promptly remit payment within 5 business days to the chiropractor or chiropractic office. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless other arrangements were made in writing. I understand I am responsible for collections fees, court costs and reasonable attorney fees to collect unpaid accounts. Return check fee $30. Any delinquent account that is sent to our collection agency will acquire additional fees. Including a 35-50% delinquency fee, and any attorney fees incurred. Any massage appointment that is not canceled 24 hours prior to scheduled appointment will be charged $15-$25.

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examinations, x-ray studies, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my patient health record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to the family member or employer of the patient for all or part of the clinic's charges, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare fund, or the patient's employer.

I hereby state that I had the opportunity to read and/or receive a copy of the HIPAA notice & consent to the professional services above.

Patient signature:____Date____________________________

Guardian signature:____Date____________________________

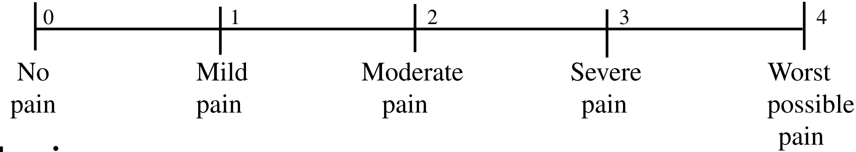
Guardian Print Name:____

Functional Rating Index

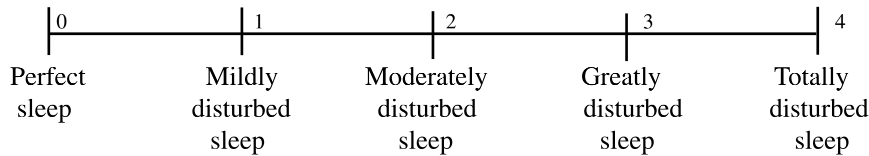
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

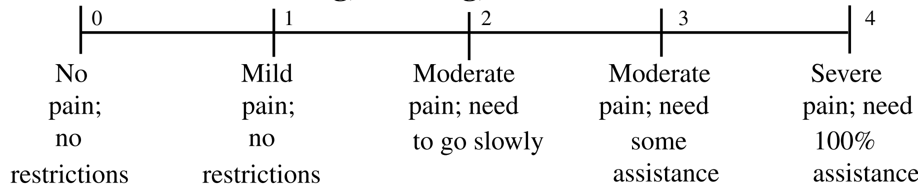
1. Pain Intensity



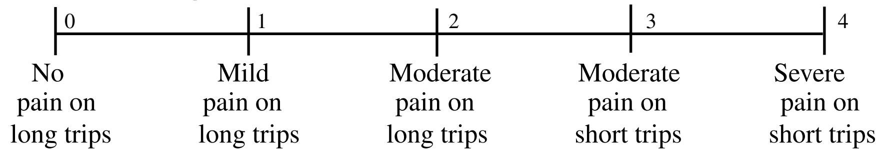
2. Sleeping



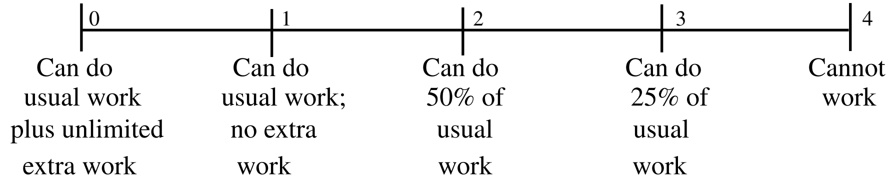
3. Personal Care (washing, dressing, etc.)



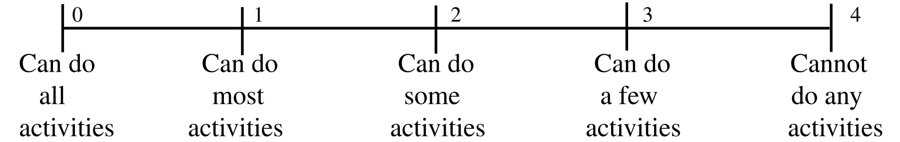
4. Travel (driving, etc.)



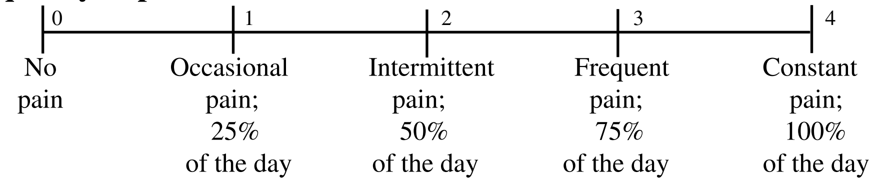
5. Work



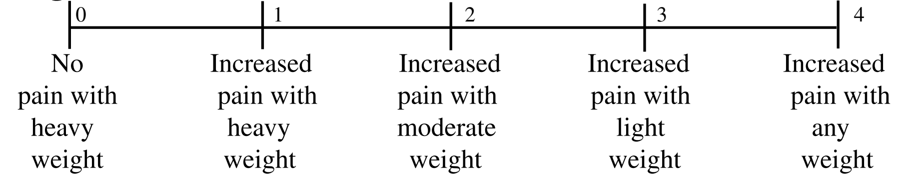
6. Recreation



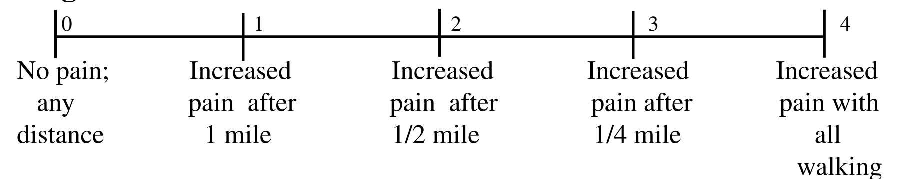
7. Frequency of pain



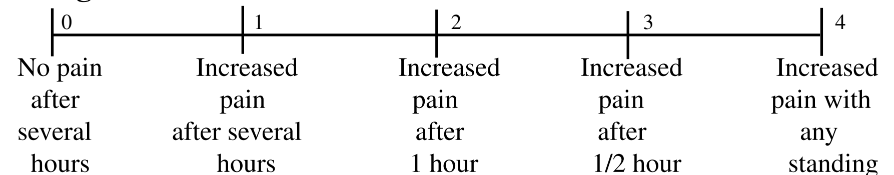
8. Lifting



9. Walking



10. Standing



Name ______________________ **ID#/SS#** ______________ **Plan ID** ________ **Total Score** ________

PRINTED

____
Signature

____
Date

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