CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date ______

SS/HIC/Patient ID # ______

Patient Name ______
Last Name

______
First Name Middle Initial

Address ______

E-mail ______

City ______

State ______ Zip ______

Sex ☐ M ☐ F Age ______

Birthdate ______

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______

Occupation ______

Employer/School Address ______

______

Employer/School Phone (____) ______

Spouse's Name ______

Birthdate ______

SS# ______

Spouse's Employer ______

Whom may we thank for referring you? ______

2 INSURANCE INFORMATION

Who is responsible for this account? ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______

Birthdate ______ SS# ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

______ and assign directly to
Name of Insurance Company(ies)

Dr. ______ 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______
Signature of Patient, Parent, Guardian or Personal Representative

______
Please print name of Patient, Parent, Guardian or Personal Representative

______ ______
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (____) ______ Home Phone (____) ______

Best time and place to reach you ______

IN CASE OF EMERGENCY, CONTACT

Name ______ Relationship ______

Home Phone (____) ______ Work Phone (____) ______

4 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) ______

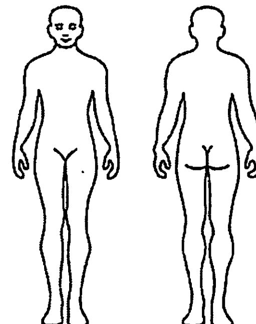
5 PATIENT CONDITION

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

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6 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:

Condition			Condition			Condition			Condition		
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	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 ________

Are you pregnant? ☐ Yes ☐ No Due Date ____________

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

7 MEDICATIONS | ALLERGIES | VITAMINS/HERBS/MINERALS

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name ________		
Pharmacy Phone (____) ________		

Chase Chiropractic Center
29050 Harper Ave. St. Clair Shores, MI 48081
586-774-0091 chasechiro.net clinic@chasechiro.net

INFORMED CONSENT TO CHIROPRACTIC CARE

This constitutes informed consent for medical, physical therapy, and/or chiropractic care. I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Chase Chiropractic Center. I understand, and am informed that, while extremely rare, there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, and strains. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

Initial __________

FINANCIAL AGREEMENT & APPOINTMENT POLICY

We, the staff at Chase Chiropractic thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship.

Understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service.

We ask for your assistance and cooperation in keeping your scheduled appointment date and time. It is Chase Chiropractic Center's policy that if the patient, no-shows or cancels an appointment with *less than 24 business hours' notice*, the patient will be charged a **$25.00 fee** (subject to change). If a need arises to cancel or change your appointment, please give the office a minimum of 24 hours' notice. Please note Monday appointments must be cancelled by 5pm on Friday.

We thank you for your cooperation and look forward to be a vital part of your recovery and maintenance.

Initial __________

Chase Chiropractic Center
29050 Harper Ave. St. Clair Shores, MI 48081
586-774-0091 chasechiro.net clinic@chasechiro.net

ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES OF CHASE CHIROPRACTIC CENTER

I acknowledge that I was provided a copy of the Notice of Privacy Practices found in the office waiting room. I acknowledge that I have read them, or declined the opportunity to ready them, and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Chase Chiropractic Center to ensure the privacy of my personal health information. I understand that this will be placed in my member chart and maintained until my further notice.

Initial ________

Please list below names of relationships to people to whom you authorize Chase Chiropractic Center to release your private health information.

Print Name	Relationship
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

______________________________ ________________
Signature/Guardian signature if under 18 Date

____
Patient name (please print)