BODY HEALING
Chiropractic

PATIENT REGISTRATION FORM

I. PATIENT DEMOGRAFICS

Name: _____ Birth Date: ____ /____ /____ Age: _____ ❑Male ❑Female

Address: _____ City _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Preferred Method of Contact: ❑ Email ❑Home Phone ❑Cell Phone

Occupation: _____ Employer:_____

Employer's Address:_____ Office Phone:_____

Do you have Insurance? ❑Yes ❑No

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other:_____

Spouse:_____ Occupation:_____ Employer:_____

Do you have children? ❑No ❑ Yes, how many? _____ Ages: _____

Are you Pregnant? ❑ No ❑Yes, If yes, how far along are you? _____ Due date: ____ /____ /____

Who is your provider(s)? _____ May we contact your provider if needed? ❑Yes ❑ No

Emergency Contact: _____ Phone: _____Relationship: _____

Whom may we thank for referring you to this office? _____

❑ Patient/Friend ❑ Physician ❑ Attorney ❑ Sports/Community Event ❑Advertisement

II. HEALTHCARE HISTORY

Is your problem the result of ANY type of injury/accident? ❑No ❑Yes, Type of Accident: ❑Auto ❑Home ❑Other

If yes, please explain: _____

Did you go to the hospital for this incident? ❑No ❑Yes, Name of Hospital: _____

Did you receive Diagnostic Imaging? ❑No ❑Yes, ❑X-ray ❑MRI ❑CT Scan ❑Performed on: _____

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Have you ever had the same or a similar condition? ❑No ❑Yes, when and describe:_____

Primary Doctor's Name: _____ Date of last visit: ____ /____ /____

Doctor's Address: _____

Reason: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ❑No ❑Yes

III. Accident Information (If you were not involved in accident/slip and fall please continue to section IV)

Type of Accident: ❑Auto vs. Auto ❑Auto vs. Object ❑Slip and Fall ❑Bike ❑Other:_____

Date of Accident: _____/_____/_____ ❑Attorney _____ ❑ Case Manager _____

Insurance Company: _____ Adjuster: _____ Adjuster Phone: _____

Policy # _____Claim # _____ State Accident Occurred: _____

I was the: ❑ Driver ❑Passenger ❑Pedestrian

If passenger: Front: ❑ Left ❑ Middle ❑ Right Center: ❑ Left ❑ Middle ❑ Right Rear: ❑ Left ❑ Middle ❑ Right Jump Seat: ❑ Left ❑ Middle ❑ Right

IV. INSURANCE INFORMATION

Please check any and all insurance coverage that may be applicable in this case**:**

❒ Major Medical ❒ Worker's Compensation ❒ Medicaid ❒ Medicare ❒ Auto Accident

❒ Medical Savings Account & Flex Plans ❒ Other:_____

Name of Primary Insurance Company:_____

Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care / Relation: _____ Date:_____

V. PRIVACY POLICY

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

The following person(s) have my permission to receive my personal health information:

❑ My Information is not to be released to anyone.

❑ _____ Relation: _____

❑ _____ Relation: _____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care / Relation: _____ Date:_____

VI. HISTORY OF PAST ILLNESS

Date of last physical examination:_____

Do you have a history of stroke or hypertension? ❑No ❑Yes, are you taking medication for it?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): ❑No ❑Yes,_____

_____

Has a physician treated you for any health condition in the last year?

❑ No ❑Yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? ❑No ❑Yes, please describe:_____

Do you have any allergies of any kind? ❑No ❑Yes, please describe:_____

Do you have any Congenital Condition? ❑No ❑Yes, please describe _____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions now or **P** if you have had these conditions previously. (**N** = Now **P** = Previously)

	N/P		N/P		N/P
Headaches		Loss of taste		Osteoarthritis	
Neck Pain		Unusual Bowel Patterns		Pacemaker	
Stiff Neck		Cold feet		Stroke	
Sleeping Problems		Cold hands		Ruptures	
Back Pain		Arthritis		Eating Disorder	
Nervousness		Muscle Spasms		Drug Addiction	
Tension		Frequent Colds		Excessive Bleeding	
Irritability		Fever		Ulcers	
Chest Pains/Tightness		Sinus Problems		Weight Loss/Gain	
Dizziness		Diabetes		Depression	
Shoulder/Neck/Arm Pain		Indigestion Problems		Loss of Memory	
Numbness in Fingers		Menstrual Difficulties		Buzzing in Ears	
Numbness in Toes		Breathing Problems		Circulation Problems	
High Blood Pressure		Fatigue		Seizures/Epilepsy	
Difficulty Urinating		Lights Bother Eyes		Low Blood Pressure	
Weakness in Extremities		Ears Ring		Osteoporosis	
Loss of Balance		Broken Bones/Fractures		Heart Disease	
Fainting		Rheumatoid Arthritis		Joint Pain/Swelling	
Loss of smell		Excessive Bleeding		Rheumatoid Arthritis	
Ulcers		Gall Bladder Problems		Breathing Problems	
Coughing Blood		Cancer		Alcoholism	
HIV Positive					

Other symptoms: _____

VII. SOCIAL HISTORY

Please indicate beside each activity whether you engage in it: OFTEN= "**O**" SOMETIMES= "**S**" NEVER= "**N**"

Vigorous Exercise		Family Pressures	
Moderate Exercise		Financial Pressures	
Alcohol Use		Mental Stresses	
Drug Use		Other:	
Caffeine Use		Other:	
High Stress Activity		Other:	

Dietary restrictions? _____

VIII. FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause: _____

_____

I certify the information provided is accurate to the best of my knowledge: _____

Patient / Guardian Signature

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: _____ Date: _____

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

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1 – What is your pain RIGHT NOW?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

_____ _____

Patient's Signature Examiner's Signature

IX. Informed Consent to Treat REGARDING: Chiropractic Adjustments Modalities and Therapeutic Procedures:

Our goals are to provide a detailed assessment of your current health status and provide to you the resources for a highly engaged and healthy body, which is functioning at its absolute peak potential. Essential is a healthy nervous system functioning free from interference called **subluxations**. Congratulations on taking an important step for your health through chiropractic evaluation!

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments. Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Body Healing Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor.

Dr. Angie Cuevas is aware of these complications, and in order to minimize their occurrence she will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect, which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant.

FEMALES ONLY: please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

The first day of my last menstrual cycle was on _____/_____/_____

At the present time: ❑ I am pregnant ❑ I am not pregnant ❑ I may possibly be pregnant

After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Patient's Name: _____

Patient's Signature: _____ Date:_____

Guardian's Signature Authorizing Care / Relation: _____ Date:_____

Name of Patient _____ Date _____

WHAT TO EXPECT AFTER YOUR FIRST ADJUSTMENT

Please read the following information carefully. Sign the bottom of the sheet to indicate that you understand the instructions and information given.

1. If you have never been adjusted, or if it has been awhile since your last adjustment, you may experience soreness or discomfort for a few hours to a few days. This is a normal reaction to chiropractic adjustments.

2. If you are sore, use ice packs on the affected area. Ice therapy consists of the use of ice packs at 20-minute intervals followed by 40 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thick towel to retain the cold.

3. Do not use heat except under the doctor's instruction. Heat may aggravate your injury.

4. Stay away from heavy lifting or repetitive movements until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting weights, impact aerobics, racquetball, tennis, skiing, bowling, etc. should be avoided. Other things to avoid are yard work such as raking, digging, lifting heavy objects such as groceries, pets and children, and any other activities that could aggravate or re-injure your condition.

5. Unless indicated by the doctor, you may return to work/school after your appointment.

6. If a sudden movement causes sharp or severe pain, or if you experience severe swelling, contact the clinic at (407) 757-0256. After hours, contact Dr. Cuevas at (954) 681-9878.

I have read and understand the instructions given for my follow-up care.

Patient's Signature: _____ Date:_____

Guardian's Signature Authorizing Care / Relation: _____ Date:_____