Yadkinville Chiropractic Center

REGISTRATION & HISTORY DATE:

PATIENT INFORMATION

Name: _____ Nickname: _____

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

Sex: M F Age: _____ Birth Date:____ / ____ / ____ Status: single married widowed separated divorced partnered
Social Security Number: _____ - _____ - _____
Occupation: _____
Employer: _____
Employer Phone: (_____) _____
Employer Address: _____
Primary Care Provider: _____
Date of last visit: _____

Whom may we thank for referring you?
_____

PHONE NUMBERS

Home: _____
Work: _____
Cell:_____
Preferred contact : Home Work Cell
Email: _____
_____

EMERGENCY CONTACT

Name: _____
Relationship:_____
Home: _____
Work: _____
Cell: _____

INSURANCE INFORMATION

Do you plan to use health insurance for your care? Yes No *(If yes, please complete the rest of this section)*

Insurance Company: _____

Relationship to insured: Self Spouse Parent/Guardian Other

Assignment & Release:

I certify that I have insurance coverage and assign directly to Yadkinville Chiropractic Center all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of this signature on all insurance submissions.

Signature: _____ Insurers Date of Birth: _____

INJURY/CONDITION

Will your visit today be for:*(please circle)* Injury Health Condition Pain Wellness Sports Performance

Was this injury related to an accident? *(please circle)* Yes No If yes, was it Work Related Auto Related Other

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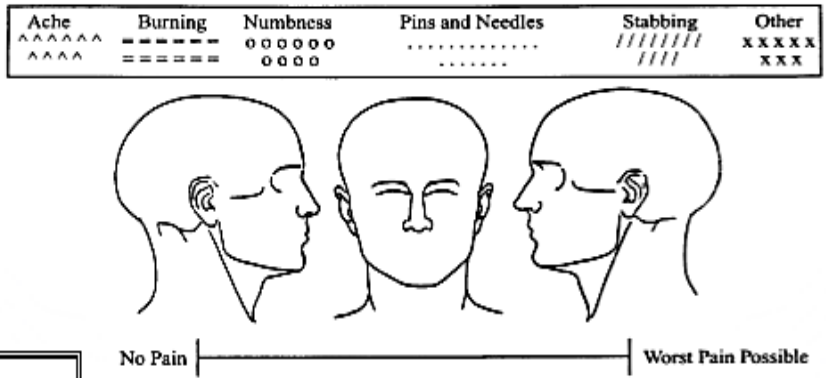
PATIENT CONDITION
Reason for Visit:
When did it start? How did it start?
Please describe your condition:
Rate your symptoms (0=worst, 10=best) /10 With time is your condition? ☐ getting better ☐ getting worse ☐ not changing
Are your symptoms constant or do they come & go? ☐ constant ☐ comes & goes
What makes your symptoms worse? ☐ standing ☐ sitting ☐ walking ☐ bending/lifting ☐ lying down ☐ sports/exercise ☐ self care
What makes your symtoms better?
What treatments have you already had for this condition: ☐ none ☐ medical ☐ chiropractic ☐ surgical ☐ physical therapy ☐ massage ☐ accupuncture ☐ other (please describe)
Have you had any recent imaging of the area? ☐ X-ray ☐ MRI ☐ CT Scan ☐ bone density/DEXA ☐ other
Does your conditon interfere with your activities (work duties, daily life, social activities, and/or recreation)? ☐ Yes ☐ No
If yes, please list 3 activites that you have difficutly with:
1.
2.
3.

Please draw your symptoms



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HEALTH HISTORY

Have you ever had any of the following:

AIDS/HIV	☐ yes	☐ no	High Cholesterol	☐ yes	☐ no	**Women Only:**	
Anemia	☐ yes	☐ no	Multiple Sclerosis	☐ yes	☐ no	Are you pregnant?	☐ yes ☐ no
Anxiety	☐ yes	☐ no	Osteopenia	☐ yes	☐ no	Due date:	
Arthritis	☐ yes	☐ no	Osteoporosis	☐ yes	☐ no	Abnormal/Painful Menstrual Cycle	☐ yes ☐ no
Asthma	☐ yes	☐ no	Pacemaker	☐ yes	☐ no		
Bleeding Disorder	☐ yes	☐ no	Parkinson 's disease	☐ yes	☐ no	Miscarriage	☐ yes ☐ no
Cancer	☐ yes	☐ no	Pinched Nerve	☐ yes	☐ no	Menopause	☐ yes ☐ no
Chemical dependency	☐ yes	☐ no	Polio	☐ yes	☐ no	**Prior Surgeries:**	**Date:**
Depression	☐ yes	☐ no	Prostate Problem	☐ yes	☐ no		
Diabetes	☐ yes	☐ no	Prosthesis	☐ yes	☐ no		
Epilepsy/Seizures	☐ yes	☐ no	Psychiatric Care	☐ yes	☐ no		
Fractures	☐ yes	☐ no	Rheumatoid Arthritis	☐ yes	☐ no		
Headaches	☐ yes	☐ no	Stroke	☐ yes	☐ no	**Additional Info:**	
Heart Disease	☐ yes	☐ no	Suicide Attempt	☐ yes	☐ no		
Hepatitis	☐ yes	☐ no	Thyroid Problems	☐ yes	☐ no		
Hernia	☐ yes	☐ no	Tumors	☐ yes	☐ no		
Herniated Disc	☐ yes	☐ no	Ulcers	☐ yes	☐ no		
High Blood Pressure	☐ yes	☐ no					

MEDICATIONS	ALLERGIES	VITAMINS/SUPPLEMENTS

FAMILY HISTORY *(Does anyone in your family have any of the following?)*

☐ Arthritis-Rheumatism	☐ Diabetes	☐ Osteoporosis/Osteopenia	☐ Other:
☐ Autoimmune Disorders	☐ Heart Disease	☐ Stroke	
☐ Back/Spine Condition	☐ High Blood Pressure	☐ Thyroid Disorder	
☐ Cancer	☐ Mental Illness		

SOCIAL HISTORY

My work duties include: ☐ standing ☐ sitting ☐ light labor ☐ heavy labor ☐ other

My exercise level is: ☐ intense ☐ moderate ☐ light ☐ minimal ☐ none

My current exercise includes: (*list activites*)

My habits include: ☐ Smoking/Tobacco use ____ packs/day ☐ Alcohol consumption ____ drinks/week
☐ Caffeine (coffee,soda,tea) ____ cups/day ☐ High Stress Level ☐ Recreational Drug use

Patient Signature _____ **Date** _____

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CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

DATE OF BIRTH _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. **This information is kept private except uses involved in your healthcare.**

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and prior health information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals

I understand that:

- I have the right to object to the use of my healthcare information for directory purposes.
- I have access to a copy of the "Notice of Patient Privacy Rights" and they are available in the office.
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that the organization is not required to agree to the restrictions requested.
- I have the right to revoke this content in writing, except to the extent that the organization has already taken action in reliance thereon.
- I have the right to request a copy of my records. I understand this require 48 hours' notice.
- I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by recipient and that this information will no longer be subject to protection as protected health information.

I request the following additional restrictions to the use or disclosure of my health information:

_____

I authorize Yadkinville Chiropractic Center to speak with the following people regarding my healthcare:

_____

With my consent, Yadkinville Chiropractic Center may call my home or other designated location, and leave a voice message in reference to any items that assist the practice in carrying out treatment, payment and health care operation, such as appointment reminders, insurance items and information pertaining to my clinical care.

With my consent Yadkinville Chiropractic Center may mail to my home any items that assist the practice in carrying out the above listed operations.

With my consent, Yadkinville Chiropractic Center may send a narrative to my primary care doctor explaining my evaluation and treatment plan.

PATIENT:

X _____ _____ _____

Signature of patient/Legal Representative | Date | Witness Signature

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INFORMED CONSENT

I understand and am informed that, as in all health care, in the practice of chiropractic there is a small inherent risk of injury which includes but is not limited to, muscle strains, sprains, fractures, dislocation, intervertebral disc injury, and cardiovascular accident. I understand that my doctor will not be able to anticipate all potential complications, but will rely on clinical expertise and judgement to determine the correct course of treatment, which will be in my best interests considering all known facts. I understand the results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

I have read and understand the preceding statements and herby consent to voluntarily participate in orthopedic, neurologic, and physical performance testing, as well as manipulative, and exercise/rehabilitation therapies as deemed appropriate. If at any time, I have further questions or decide not to continue to consent in treatment, I understand I have the right and it is my duty to notify my doctor.

_____ _____ _____

PRINT PATIENT NAME SIGNATURE DATE

If patient is a minor:

_____ _____ _____

PRINT PARENT/GUARDIAN NAME SIGNATURE DATE

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AUTHORIZATION FOR RELEASE OF CASE RECORDS

I,_____ hereby authorize any physician, hospital, or other health care provider to release Yadkinville Chiropractic Center, any information regarding my medical history, diagnostic testing, treatment, exam results, or diagnosis for the purpose of coordinating my healthcare.

Date of Birth: _____

Signature: _____

Date: _____