EASTLAKE CHIROPRACTIC AND MASSAGE CENTER, PS

PATIENT REGISTRATION

Patient: _____ Date of birth _____ Today's Date_____ ☐ Male ☐ Female
LAST FIRST MIDDLE

Address: _____ Social Security #: _____

City, State, Zip: _____ EMAIL:_____

Phone # (_____)_____ Work phone # (_____) _____Ext _____

Whom may we thank for referring to our office?:_____

Marital Status: ☐ M ☐ S # of Children _____ages_____ Spouse/Partner's Name: _____

CMS requires providers to report both race and ethnicity

Race (Circle one): I Decline to Answer / White (Caucasian) / Asian / Black or African American / American Indian or Alaska Native / Native Hawaiian or Pacific Islander / Other

Ethnicity (Circle one): I Decline to Answer / Hispanic or Latino / Not Hispanic or Latino

Medical Doctor Name:_____ Clinic Name:_____

Occupation: _____ Employer: _____

If you are a visitor please give your local address and phone #: _____

In Case of emergency, notify _____ Relationship _____Phone # (_____)_____

Any person (s) responsible for payment other than you?: Y / N If Yes, Name:_____

Address:_____Phone # (_____)_____

INSURANCE : PLEASE SUPPLY INFORMATION FOR BOTH INSURANCE CARRIERS IF APPLICABLE

Is this an: _____ Auto Accident? _____ Work related ? _____ Other? Date of Injury: _____

Primary Carrier Name: _____ Secondary Carrier Name: _____

Phone # (_____) _____Policy /Claim # _____ Phone #: (_____) _____Policy/Claim #_____

Insured: _____DOB _____ Insured:_____ DOB _____

ID #: _____ Group # _____ ID #: _____Group # _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Eastlake Chiropractic and Massage Center will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Eastlake Chiropractic and Massage Center will be credited to my account receipt. However, I clearly understand and agree that all services rendered me are charged 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 service rendered me will be immediately due and payable. I hereby agree that I will be assessed one percent (1%) charge per month on any fee not kept current. I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient or Guardian's Signature: _____ Date: ____/____/_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Eastlake Chiropractic and Massage Center (ECC) 'Notice of Privacy Practices'. This Notice describes how ECC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____
Initials

APPOINTMENT/ CANCELLATION POLICY

In order to serve all our patients we ask that you call if you are unable to make your appointment or even if you find yourself running late. We will do our best to accommodate you and get you in for your visit as soon as possible. When you fail to notify our office, this leaves a time slot open that could otherwise be used to help someone else.

CANCELLATION POLICY

We require 24 hours notice if you are unable to keep your appointment. Failure to give ample notice or not show will result in a fee of $50 for massage and $35 for chiropractic. We do understand that there are things we cannot control in life and this policy does not apply to a true emergency.

_____
Initials

PATIENT'S NAME_____ DATE ___/___/___

PATIENT'S Signature _____ DATE___/___/____

PARENT/GUARDIAN SIGNATURE (if required)_____

EASTLAKE CHIROPRACTIC AND MASSAGE CENTER, PS

PATIENT INTRODUCTION FORM

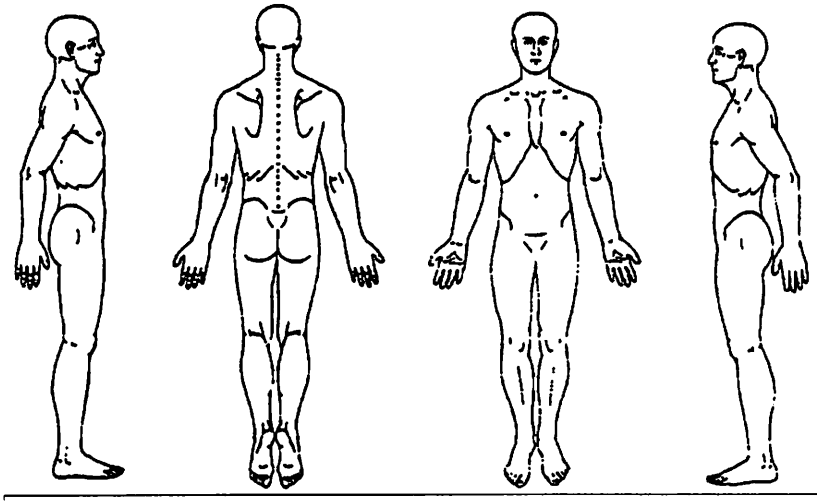
NAME_____ TODAY'S DATE___/___/_____

WOMEN–ANY POSSIBILITY YOU COULD BE PREGNANT? **Y / N** IF YES 1ST DAY OF LAST CYCLE___/___/___

REASON(S) FOR CONSULTING THIS OFFICE: _____

_____

_____



How often do you experience your symptoms?

___ Constantly (76-100% of the day)
___ Frequently (51-75% of the day)
___ Occasionally (26-50% of the day)
___ Intermittently (0-25% of the day)

Describe the pain (circle all that apply):

Deep	Superficial	Numb
Sharp	Burning	Tingling
Dull Achy	Throbbing	Shooting

How are your symptoms changing?

___ Getting Better
___ Not Changing
___ Getting Worse

Use the following scale to rate your pain=> **MILD MODERATE SEVERE DISABLING**
1 2 3 4 5 6 7 8 9 10+

Generally or **right now** = ____/10
When you feel the **best**: = ____/10
When you feel the **worst**:= ____/10

HAVE YOU RECEIVED CARE FOR YOUR CURRENT CONDITION? Y / N
IF YES, List any healthcare professionals seen for your current problem(s):_____

_____

Check the type of treatments you've had for your **current problem**(s):

___Ice ___Heat ___Physical Therapy ___Massage therapy ___Stretching ___Medication ___Surgery

___Chiropractic ___Exercise ___Acupuncture ___Other_____

Have you ever had these problems/symptoms before: **Y / N** Which_____

ON A SCALE FROM 1—10 WHICH OF THE BELOW EVERYDAY ACTIVITIES ARE IMPACTED BY YOUR SYMPTOMS? 1 = MILD AND 10 = SEVERE

___Computer work ___ Sitting ___ Lifting ___Bending ___ Getting in/out of chair/bed

___ Standing ___ Walking ___ Running ___ Sleeping ___Reading ___ Exercise

___ Other_____

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Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

Chiropractic care centrally involves what is known as a chiropractic adjustment but also may involve some diagnostic or examination procedures if indicated. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns from hot or cold packs, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. It has been reported that chiropractic care can pose a rare risk of stroke or cervical vascular injury or even death.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Each of these treatment options poses its own related risk. Ask your primary care doctor about these risks. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____

Signature: _____ Date: _____

Parent or Guardian: _____

Signature: _____ Date: _____

Witness Name _____

Signature: _____ Date: _____

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WHICH OF THE FOLLOWING HAVE YOU BEEN EXPERIENCING DIFFICULTY WITH OR BEEN DIAGNOSED WITH: (PLEASE CHECK ALL THAT APPLY)?

___HEADACHES
___NECK PAIN
___NECK STIFFNESS
___BACK PAIN
___BACK STIFFNESS
___DISC PROBLEMS
___SHOULDER PAIN
___ARM PAIN
___ELBOW PAIN
___WRIST PAIN
___HAND/ FINGER PAIN
___TINGLING IN ARM/HAND
___COLD HANDS
___HIP PAIN
___LEG PAIN
___KNEE PAIN
___ANKLE PAIN
___FOOT/ TOE PAIN
___TINGLING IN LEGS/ FEET
___COLD FEET
___SWOLLEN ANKLES
___PAINFUL JOINTS
___ARTHRITIS
___NIGHT PAIN
___EXCESSIVE FATIGUE
___POOR DIET
___FAINTING
___NAUSEA
___NERVOUSNESS
___FREQUENT COLDS
___SINUS PROBLEMS
___ALLERGIES
___ASTHMA
___EAR INFECTIONS
___STOMACH PROBLEMS
___SWALLOWING
___CONSTIPATION
___DIARRHEA
___ABNORMAL STOOLS
___PAINFUL BOWEL MOVEMENTS
___KIDNEY PROBLEMS
___BLADDER PROBLEMS
___PROSTATE PROBLEMS
___MENSTRUAL PROBLEMS
___GALL BLADDER PROBLEMS
___LIVER PROBLEMS
___CHEST PAINS
___HIGH BLOOD PRESSURE
___LOW BLOOD PRESSURE
___HEART PROBLEMS
___HEART ATTACK/ DISEASE
___STROKE
___DIABETES
___ANEMIA
___THYROID PROBLEMS
___OSTEOPOROSIS
___CANCER
___DIZZINESS/VERTIGO
___BALANCE PROBLEMS
___COORDINATION PROBLEMS
___VISION PROBLEMS
___DEPRESSION

ANY CONDITION/CONCERN NOT LISTED ABOVE_____

Have you had any significant trauma in the past (auto accidents, sports injuries, falls, etc.): Y / N
If yes, give description / date of each:_____

_____

List any operations and dates of each:_____

List any diseases and dates of each:_____

Are you presently taking any medication: Y / N Is it for your current problem: **Y / N**
List any name(s), dosage and reason you are taking medication:_____

_____

Do you have any medication allergies? Y / N If yes, What?:_____

EXERCISE: ___ NEVER ___ LIGHT (1-2X per week) ___ MODERATE (3-4X per week) ___ INTENSE (5+X per week)

Types of exercise :_____

SMOKING STATUS: Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked
ALCOHOL STATUS: Every Day Drinker / Occasional Drinker / Former Drinker / Never Drank
RECREATIONAL DRUGS: Y / N WHAT AND HOW OFTEN?_____

RATE YOUR TYPICAL STRESS LEVEL (OVERALL): 1 2 3 4 5 6 7 8 9 10+
MILD MODERATE SEVERE DISABLING

HAVE ANY OF YOUR BLOOD RELATIVES BEEN AFFECTED BY THE FOLLOWING CONDITIONS: (Indicate which family member. For example: Father, mother, grandmother, grandfather, aunt, uncle, etc.)

_____RHEUMATOID ARTHRITIS _____HEART DISEASE _____HIGH BLOOD PRESSURE
_____STROKE _____DIABETES _____CANCER
OTHER_____

What is your height and Weight? Height: ___/___ ___ Weight:_____ lbs

I have read and reviewed the information herein and represent that the same is true, correct and complete. I understand that the doctor is relying upon the information in rendering treatment.

Patient signature_____ Date:___/___/_____

The Revised Bournemouth Questionnaire

NAME _____ DATE _____ AGE _____

The following scales have been designed to find out about your pain 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. Over the past week, on average, how would you rate your pain?

No pain									Worst pain possible
0	1	2	3	4	5	6	7	8	9	10

2. Over the past week, how much has your pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference									Unable to carry out activity
0	1	2	3	4	5	6	7	8	9	10

3. Over the past week, how much has your pain interfered with your ability to take part in recreational, social, and family activities?

No interference									Unable to carry out activity
0	1	2	3	4	5	6	7	8	9	10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/ relaxing) have you been feeling?

Not at all anxious									Extremely anxious
0	1	2	3	4	5	6	7	8	9	10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed									Extremely depressed
0	1	2	3	4	5	6	7	8	9	10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your pain?

0	1	2	3	4	5	6	7	8	9	10

7. Over the past week, how much have you been able to control (reduce/help) your pain on your own?

Completely control it									No control whatsoever
0	1	2	3	4	5	6	7	8	9	10