New Patient Registration From

DATE: _____ How did you hear about us: _____

Name (Last, Frist, Middle): _____

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

DOB: _____ Age: ____ SSN: _____ Phone: _____

Email: _____ Occupation: _____

Marital Status: ___Married ___ Single ___Divorced ___Widowed

Spouse name: _____ Phone: _____

Emergency contact name: _____ Phone: _____

- If patient is a minor (under the age of 18) please fill out the Minor form.

1st Complaint

1st Complaint: _____Date started_____

What is the history of this injury or symptom? _____

_____

What makes the issue worse? _____

What makes the issue better? _____

How would you describe the pain? _____

What is the location or radiation of the pain? _____

Time of day or week are the symptoms worse? _____

How bad is the pain 0-10? 0 = no pain & 10 = unbearable pain

Now: __/10 Average: __/10 Best: __/10 Worst: __/10

How often are the symptoms present?

__ Intermittently __ Occasionally __ Frequently __ Constant

How long can they last? ___Minutes ___ Hours ___Day(s) ___ Week(s)

What daily activities have been affected? _____

Have you received any treatment for this condition if so, what? _____

Please use a **Y** or **N** when answering any of the following. If not sure leave a **?**

__ Do you have a history of cancer?

__ Does your pain not improve with rest?

__Is there numbness in the groin region?

__Increasing muscle weakness in the legs?

__ Do you have osteoporosis (weak bones)?

__Intravenous drug use?

__Immunosuppression medication & or condition?

__Have you had spinal pain greater than 4 weeks?

__Trouble starting or stopping bowel movements?

__Minor trauma in person > 50 years old?

__Any history or prolonged use of corticosteroids?

__No response to 4-6 weeks of conservative care?

__Current or recent infection?

2nd Complaint

2nd Complaint: _____ Date started_____

What is the history of this injury or symptom? _____

_____

What makes the issue worse? _____

What makes the issue better? _____

How would you describe the pain? _____

What is the location or radiation of the pain? _____

Time of day or week are the symptoms worse? _____

How bad is the pain 0-10? 0 = no pain & 10 = unbearable pain

Now: __/10 Average: __/10 Best: __/10 Worst: __/10

How often are the symptoms present?

__ Intermittently __ Occasionally __ Frequently __ Constant

How long can they last? __Minutes __ Hours __Day(s) __ Week(s)

What daily activities have been affected? _____

Have you received any treatment for this condition if so, what? _____

Please put the letter that applies to the following work or home activities.

A: Able R: Restricted U: Unable

1. Sit in office Chair _____
2. Stand on concrete _____
3. Climb steps/stairs _____
4. Stoop to retrieve _____
5. Crouch to retrieve _____
6. Kneel to retrieve _____
7. Reach overhead _____
8. Lift waist to shoulder__
9. Carry 100 feet _____
10. Push _____
11. Pull _____
12. Balance _____
13. Crawl _____
14. Reach _____
15. Handling _____
16. Fingering_____

NOTES:

_____

_____

_____

Signature of patient _____ Date:_____

Medical History

1. List any current medical problems and approximate dates:_____
   _____
   _____
2. List any medication and dosage: _____
   _____
3. List ALL allergies: _____
   _____
4. List any major surgeries and approximate dates: _____
   _____
5. Family history - Please place a number of the family member if applicable next to condition: (1. Father, 2. Mother, 3. Sister, 4. Brother)

   : Cancer _____
   : Diabetes _____
   : Heart disease_____
   : High blood pressure_____
   : Epilepsy_____
   : Mental disorders____
   : Tuberculosis_____
   : Thyroid diseases_____
   : Kidney diseases_____
   : Muscle bone or nerve diseases____
   : Rheumatoid arthritis_____
   : Blood disorder_____
   : Rheumatic fever____
   : Other_____

6. Please answer the following questions **(Circle the ones that apply)**

   :Do you have high blood pressure? Y N
   : Do you have diabetes? Y N
   : Do you smoke cigarettes, how many per day? Y N ____
   : Caffeine per day - Soda, coffee, Tea, other _____
   : Alcohol - glass of wine, beer, or mixed drink: _____ per day/ week/ or month.
   : Exercise -Type_____, How often _____ week, day, or month.
   : Height ____ft _____in Weight _____ Blood pressure___/____ Pulse ____

7. Race/Ethnicity

   : White/Caucasian
   : American Indian
   : Black/African American
   : Other
   : Hispanic/Latino, Spanish origin
   : Native Hawaiian
   : Asian origin

8. Language spoken

   : English :Spanish : Hmong : French : Italian : German : Other

Review of systems please use the number corresponding when answering.

1. Current, 2. Past and 3. Related to accident.

General Symptoms

__Headache
__Fever
__Chills
__Night sweats
__Fainting
__Dizziness
__Loss of sleep
__Fatigue
__Loss of weight
__Numbness
__Pain
__Wheezing

Muscle & Joints

__Weakness
__Twitching
__Stiff or Tender
__Swollen
__Foot problems
__Pain in tail bone
__Pain between shoulders
__Swelling ankles
__Poor circulation
__Varicose veins
__Strokes
__Palpitations

Gastro-Intestinal

__Poor appetite
__ Poor digestion
__ Belching or gas
__Nausea
__Vomiting
__Vomiting blood
__Pain over stomach
__Constipation
__Diarrhea
__Colon trouble
__Hemorrhoids
__Fluid retention
__Liver trouble
__Gout
__Gall bladder

Cardiovascular

__Rapid heart
__Slow heart
__Low blood pressure
__Pain over heart

Respiratory

__Chronic cough
__Spiting blood
__Spiting phlegm
__Chest pain
__Difficulty breathing

Other: Anything we haven't asked

_____

_____

Eye/Ear/Nose/Throat

__Poor vision
__Crossed eyes
__Pain in eyes
__Deafness
__Earache
__Ringing in ears
__Nasal obstruction
__Nose bleeds
__Sinus trouble
__Sore throat
__Asthma
__Enlarged Thyroid
__Tonsilitis

Skin Allergies

__Bruising easily
__Itching
__Dryness
__Boils
__Sensitive skin
__Shingles
__Eczema

Genito-Urinary

__Frequent urination
__Painful urination
__Blood in urine
__Kidney infection
__Bed wetting
__Inability to control urine
__Prostate trouble

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device to move your joint. You may feel a "click" or "pop" such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or traction my also be use.

Possible risks: As with any health care procedure, complication is possible following a chiropractic manipulation. Complication could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or other minor complications.

Probability of risks occurring: The risk of complication due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or store has been estimated at one in 1 million to 1 in 10 million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment option that could be considered may include the following:

- Over the counter analgesics. The risks of these medication include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases

Risk of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make further rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____	_____	_____
Print name	Signature	Date

REQUIRED FEDERAL PRIVACY AUTHORIZATION AND CLINIC POLICY

10/01

Federal Guidelines to assure your privacy are strictly adhered to at Eastside Chiropractic. Eastside Chiropractic's clinic policies are actually more restrictive than federal law requires. The most important guidelines are described as follows:

Your privacy as a patient at this office is kept in the strictest of confidence. Only members of the staff that are qualified to and required by their job descriptions have access to your personal contact information and, perhaps more importantly, your health information. Eastside Chiropractic is required to release your health information under some circumstances, for example, to other health care providers we are coordinating care with or to your insurance company. Eastside Chiropractic will not release your private information to anyone who does not have a right to your information.

Eastside Chiropractic will need your authorization to contact you and leave messages for you to contact the office for reasons such as appointment reminders. Messages may be be left on:

Answering machines, voice mail or pagers.
With any person at your residence or workplace.
Via email.

Eastside Chiropractic will need your authorization to forward to you written pieces regarding issues such as:

Informational.
Health condition related.
Alternative treatment related.
Marketing materials (ie. business cards).

It is the policy of Eastside Chiropractic not to reveal any information about you to any outside marketing company. Any alteration to the privacy policy of Eastside Chiropractic will be provided to you, in writing, for your written consent. You may inspect or copy the information Eastside Chiropractic utilizes to contact you at any time.

Unfortunately, information that we disclose to qualified parties may be re-disclosed by them and no longer be protected by federal privacy rules. You may further request we not release information to specific individuals, companies or organizations and although we do not have to agree to your restriction if we do, the agreement is binding on us. You may revoke your consent to information release at anytime by written consent. However, information previously released by the date of your revocation is not subject to that authorization revocation. If you do not give Eastside Chiropractic authorization it will not affect the treatment Eastside Chiropractic provides to you or the methods we use to obtain reimbursement for your care.

I authorize Eastside Chiropractic to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this required Federal Privacy Authorization and Clinic Policy document.

Patient's Signature: _____ Date: _____

Printed name: _____

Signature of personal representative/guardian: _____

Printed name of personal representative/guardian: _____

Relationship of personal representative/guardian to patient: _____