



## Chiropractic Registration & History

**Patient Information:** (Please print clearly and fill in completely)

Print Name \_\_\_\_\_ Email \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_

Phone \_\_\_\_\_ (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

(Work) \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

SSN: \_\_\_\_\_

IN CASE OF EMERGENCY: Name \_\_\_\_\_ Phone \_\_\_\_\_

Relation \_\_\_\_\_

Do you have insurance that you believe may cover part of your chiropractic care?

Please Check  Yes  No  Name or type of insurance: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Insured's date of birth: \_\_\_\_\_

Are you covered by more than one insurance company?  Yes  No Name \_\_\_\_\_

### Health History:

Give reason for seeking chiropractic care: \_\_\_\_\_

Describe any health problems, including how long you've had them: \_\_\_\_\_

Are you under the care of any other doctor? Yes/No If Yes, explain conditions being treated for: \_\_\_\_\_

List any current Medications: \_\_\_\_\_

List any current Allergies: \_\_\_\_\_

List any past surgeries & dates: \_\_\_\_\_

List any past accidents & dates: \_\_\_\_\_

List any x-rays you've had in the past 2 years \_\_\_\_\_

## Personal & Family History:

Your Occupation: \_\_\_\_\_ Work Duties \_\_\_\_\_

Spouse's health status \_\_\_\_\_

Children's ages and health status: \_\_\_\_\_

Please review the below-listed diseases and conditions and indicate those that are recurrent health problems of a family member. Leave blank those that do not apply. If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar environments.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTER(S)		CHILDREN		
	Age( )	Age( )	Age( )	Age( )	Age( )	Age( )	Age( )	Age( )	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:										

## Health/Lifestyle/Social History

Tobacco usage None Light Moderate Heavy

Alcohol usage None Light Moderate Heavy

Drug usage None Light Moderate Heavy

Exercise Never Seldom Occasional Regularly

Do you drink coffee? Yes /No How many cups / day? \_\_\_\_\_

Do you take any supplements (i.e. vitamins, minerals, herbs)? \_\_\_\_\_

## Chiropractic History:

Have you ever been to a Chiropractor before? Yes/No If yes, Doctor's Name \_\_\_\_\_

Date of last chiropractic visit \_\_\_\_\_ Reason for care \_\_\_\_\_

Date of last chiropractic x-rays \_\_\_\_\_ How long were you under care? \_\_\_\_\_

Are other family members under chiropractic care? - Yes/No Who? \_\_\_\_\_

## Rate Your Overall Health

At Alignment Specific Chiropractic Clinic we are dedicated toward achieving your goal of total lasting health for each of our practice members. To better help you achieve this; we need to understand how you view your overall health. Based on a scale of 10% to 100%, please **circle** what you feel is your current level of health and wellness.

10% ----- 20% ----- 30% ----- 40% ----- 50% ----- 60% ----- 70% ----- 80% ----- 90% ----- 100%---

## Referrals

Our clinic is primarily referral based. We would like to know whom we could thank for sending you to us. Please let us know who referred you, or where you hear about our clinic? \_\_\_\_\_

**Females:** *Please Check One* ✓ Is there a possibility of you being pregnant? Yes  No

## X-Ray

I \_\_\_\_\_ do hereby give my consent to allow Alignment Specific Chiropractic Clinic and it's representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant \_\_\_\_\_ ( Initial )

Signature of Patient/or Guardian of said Minor \_\_\_\_\_ Date \_\_\_\_\_

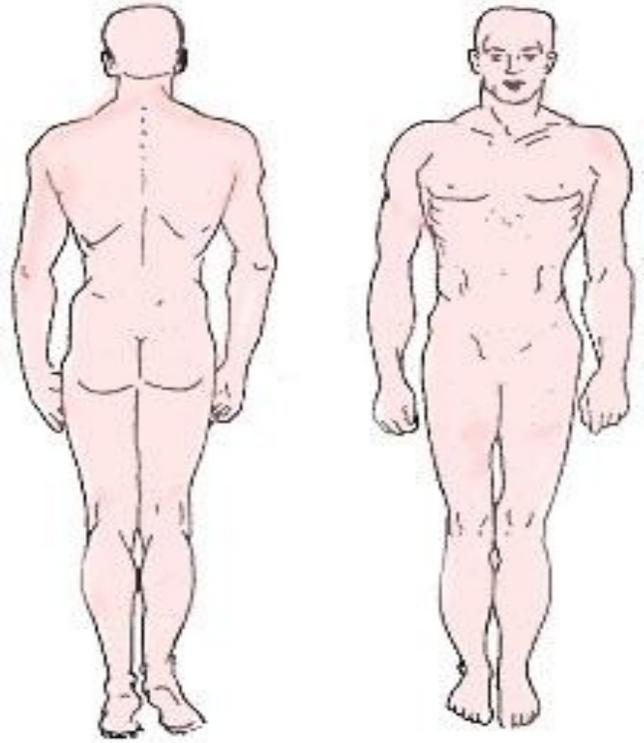
Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please Fill in Below**

If you currently or recently have suffered from the following, *Please Check* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
Female problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problem	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Circle the areas where you have any problems. Please also describe these problems.



Please use the space below to fill in any additional health information you feel we may need for your care.

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**Pain Scale 0=Best 10= Worst**

Problem 1: \_\_\_\_\_

1---2---3---4---5---6---7---8---9---10

Problem 2: \_\_\_\_\_

1---2---3---4---5---6---7---8---9---10

Problem 3: \_\_\_\_\_

1---2---3---4---5---6---7---8---9---10

Problem 4: \_\_\_\_\_

1---2---3---4---5---6---7---8---9---10

## **Informed Consent For Chiropractic Care**

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there may be a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Prior to receiving care in this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help you become healthier prior to beginning care.

### **The availability and nature of other treatment options, which may include:**

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

### **The risks and dangers attendant to remaining untreated.**

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

### **DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW**

I have read “ or have had read to me “ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Thomas A Taylor III, and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness Signature (Office Staff)

\_\_\_\_\_  
Date

# ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I \_\_\_\_\_ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

- \* The right to review the notice prior to signing this consent
- \* The right to object to the use of my health care information for directory purpose
- \* The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

**PRIVACY NOTICE ACKNOWLEDGEMENT** We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them. I have read and understand the Patient Privacy Procedures of: Alignment Specific Chiropractic Clinic, LLC.

\_\_\_\_\_  
Signature of Patient/or Guardian of said Minor

\_\_\_\_\_  
Date

## Missed Appointment's

Due to high patient volume we require to give at least **24 hours notice** if you want to change your appointment, there will be a \$25.00 fee charged for all missed appointment.

### Office Hours:

**Monday** 3:00-5:30

**Tuesday** 9:00-1:00 3:00-6:30

**Friday** 10:00-1:00

**Wednesday** 3:00-5:30

**Thursday** 9:00-1:00 3:00-6:30

By signing below you are agreeing that you have been informed of ASCC office policy in regards to the missed appointment fee and office hours.

Signature \_\_\_\_\_ Date \_\_\_\_\_