CHIROPRACTIC REGISRATION AND HISTORY

PATIENT INFORMATION

Date _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City/State/Zip _____ WA

Cell Phone _____

Home Phone _____

e-mail/carrier _____

Gender _____ Age _____

Date of Birth _____

Married ____ Widowed _____ Divorced _____ Single _____

Employer _____

Occupation _____

Work No. _____

Spouse Name _____

Date of Birth _____

IN CASE OF EMERGENCY CONTACT:

Name _____

Relationship _____

Home No. _____

Cell No. _____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to patient _____

Insurance Company _____

ID # / Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to **Dr. Taylor** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my healthcare information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient _____

Whom may we thank for referring you?

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? _____ Yes _____ NO _____ Unknown

Rate the severity of your pain on a scal from 1 (least pain) to 10 (severe pain) _____

Type of Pain: ____ Sharp ____ Dull ____ Throbbing ____ Numbness ____ Aching ____ Shooting ____ Burning ____ Tingling
____ Cramps _____ Stiffness ____ Swelling ____ Other _____

How often do you have this Pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ____ Work ____ Sleep ____ Daily Routine ____ Recreation

Activities or movements that are painful to perform ____ Sitting ____ Standing ____ Walking ____ Bending ____ Lying Down

Patient Name Date Account:

HEALTH HISTORY

What treatment have you already received for your condition? _____ Medications _____ Surgery _____ Physical Therapy

_____ Chiropractic Services _____ None _____ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "YES" or "NO" to indicate if you have had any of the following:

AIDS/HIV	__YES ___NO	Emphysema	__YES ___NO	Liver Disease	__YES ___NO	Rheumatoid Arthritis	__YES ___NO
Alcoholism	__YES ___NO	Epilepsy	__YES ___NO	Measles	__YES ___NO		
Allergy Shots	__YES ___NO	Fractures	__YES ___NO	Migraines	__YES ___NO	Rheumatic Fever	__YES ___NO
Anemia	__YES ___NO	Glaucoma	__YES ___NO	Miscarriage	__YES ___NO		
Anorexia	__YES ___NO	Goiter	__YES ___NO	Mononucleosis	__YES ___NO	Scarlet Fever	__YES ___NO
Appendicitis	__YES ___NO	Gonorrhea	__YES ___NO	Multiple Sclerosis	__YES ___NO	Stroke	__YES ___NO
Arthritis	__YES ___NO	Gout	__YES ___NO			Suicide Attempt	__YES ___NO
Asthma	__YES ___NO	Heart Disease	__YES ___NO	Mumps	__YES ___NO		
Bleeding Disorders	__YES ___NO	Hepatitis	__YES ___NO	Osteoporosis	__YES ___NO	Thyroid Problems	__YES ___NO
Breast Lump	__YES ___NO	Herniated Disk	__YES ___NO	Pacemaker	__YES ___NO	Tonsilitis	__YES ___NO
Bronchitis	__YES ___NO	Hepatitis	__YES ___NO	Parkinson's Disease	__YES ___NO	Tuberculosis	__YES ___NO
Bulimia	__YES ___NO	Hernia	__YES ___NO	Pinched Nerve	__YES ___NO	Tumors	__YES ___NO
Cancer	__YES ___NO	High Blood Pressure	__YES ___NO	Pneumonia	__YES ___NO	Typhoid Fever	__YES ___NO
Cataracts	__YES ___NO	High Cholestrol	__YES ___NO	Polio	__YES ___NO	Ulcers	__YES ___NO
Chemical Dependency	__YES ___NO	Kidney Dis	__YES ___NO	Prostate Problem	__YES ___NO	Vaginal Infections	__YES ___NO
Chicken Pox	__YES ___NO			Prosthesis	__YES ___NO	Whooping Cough	__YES ___NO
Diabetes	__YES ___NO			Psychiatric	__YES ___NO		

EXERCISE

_____ None
_____ Moderate
_____ Daily
_____ Heavy

WORK ACTIVITY

_____ Sitting
_____ Standing
_____ Light Labor
_____ Heavy Labor

HABITS

_____ Smoking Packs/Day _____
_____ Alcohol Drinks/Week _____
_____ Caffeine Cups/Day _____
_____ Recreation Drugs _____

Are you pregenant? _____ Yes _____ No Due Date _____

Injuries/Surgeries you have had	Description	Date

MEDICATION

_____
_____

ALLERGIES

_____
_____

VITAMINS/HERBS/MINERALS

_____
_____

Patient Name:

What is your current problem and when did it begin? Also, on a scale from 0-10, 10 being the worst please circle the number that best describes the symptom most of the time.

1._____ 0 1 2 3 4 5 6 7 8 9 10

2._____ 0 1 2 3 4 5 6 7 8 9 10

3._____ 0 1 2 3 4 5 6 7 8 9 10

4._____ 0 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptoms?

1._____ 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

2._____ 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

3._____ 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

4._____ 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

What makes the symptom worse? (Circle all that apply): Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):_____

What makes the symptom better? (Circle all that apply): rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe):_____

Describe the quality of the symptom (Circle all that apply): Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging other (please describe): _____

Does the symptom radiate to another part of your body? (Circle one): YES NO

If yes, where does the symptom radiate?_____

Is the symptom worse at certain times of the day or night? (Circle one): Morning Afternoon Evening Night Unaffected by the time of day

Have you had to modify your lifestyle in any way due to these symptoms? (Circle one): YES NO

If yes, please describe:_____

Patients Signature: _____

STAFF ONLY: _____ BP _____ Pulse _____ L _____ R – Weight Scales _____ Height

_____ L _____ R – Grip Strength Any NEW Allergies? Y N What?_____

Any NEW Surgeries? Y N What?_____ When? _____

Any NEW Medications? Y N What? _____

Exercise? Y N daily weekly What type? _____ Caffiene? Y N _____

_____ (Signature of Staff)

Plateau Chiropractic & Massage

22647 NE Inglewood Hill Rd

Sammamish, WA 98074

425-868-9593

Account No.:

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

I acknowledge that I have been provided a readable copy of the Notice of Privacy Practices (HIPPA):

- It tells me how Plateau Chiropractic & Massage will use my health information for the purposes of my treatment, payment for my treatment and health care operations.
- The Notice explains in more detail how Plateau Chiropractic & Massage may use and share my health information for other than treatment, payment and health care operations.
- Plateau Chiropractic & Massage will also use and share my health information as required/permitted by law.
- It tells me that I can go to www.plateauchiropractic.com to print out a copy or I can request it to be e-mailed to me or I can request a paper copy of the Notice of Privacy Practices.

Patient's Complete Legal Name: _____

Patient's DOB: Date: _____

Signature: _____

(Patient or legal representative*)

*May be requested to show proof of representative status