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

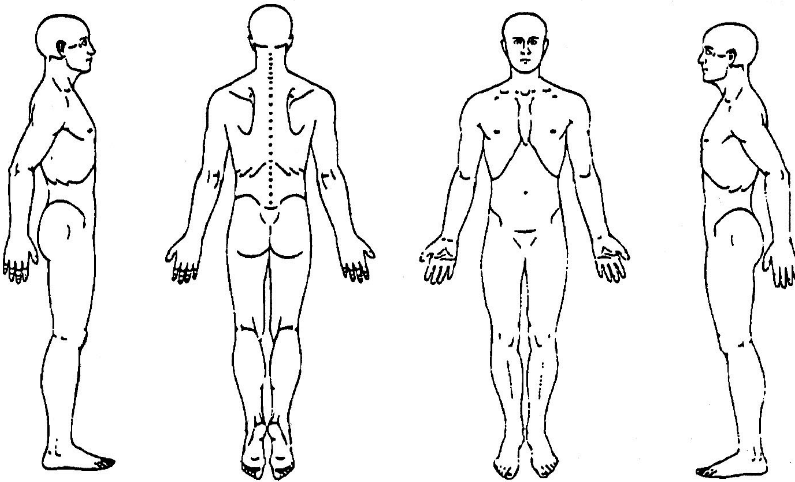
NAME____TODAY'S DATE____/____/________

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____

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:___/___/______