Patient Registration Form

We offer a unique service to individuals and families. We are happy you have chosen to use our services. We will make every effort to make your experience supportive, informative and healing.

Please complete the following:

Name_____

Address_____City _____State_____Zip_____

Date of Birth _____Age _____Marital Status S M W D

Occupation_____ Employer_____

Best Phone Number _____ Email Address_____

Partner's Name_____Name & Ages of Children_____

Previous chiropractic care (please circle one) Y N If Yes, with whom: _____

For How Long_____Date of Last Visit_____

Why did you stop care?_____

How did you learn about our office?_____

Signature_____Date_____

Our mission is to promote and support the overall health, wellbeing and highest quality of life of all individuals and families in our community through natural and affordable chiropractic care.

Confidential Health Entrance Form

In order for us to better understand your current level of health, please circle any of the body signals which you are currently experiencing:

Allergies	Depression	IBS	Sinus Problems
Anxiety	Dizziness/Vertigo	Latching Issues	Stress Relief
Arthritis	Ear Infections Frequent	Menstrual/ Menopausal	TMJ Problems
Asthma	Cold/ Flu	Neck Pain	Torticollis
Back Pain	Headaches/Migraine	Numbness and Tingling	Pregnancy
Body Image	Heartburn/Reflux	Poor Posture	Other_____
Breech Baby	High Cholesterol	Sciatica	
Colic	Hip Pain/ Leg Pain		
Constipation	Infertility		

Please circle the following conditions that you have or have had:

Alcoholism	Heart Disease	Kidney Disease	Scoliosis
Cancer _____	Hypertension	Lung Disease	Stroke
Diabetes	HIV	Lyme Disease	Ulcers
Epilepsy	Hyper/Hypothyroidism	Multiple Sclerosis	Other_____

Please list ALL prescription and OTC medications as well as vitamins/supplements you are currently taking:

_____

Are any of your medications blood thinners (circle one)? Y N

Signature_____ Date_____

Patient Health History

Motor Vehicle

- Have you *ever* been in a motor vehicle accident? Y N

If yes, please tell us about the MOST significant motor vehicle accident you were involved in:

Year it occurred	Impact of Collision (circle ONE)	Speed of Collision	Treatment Received
	Front I Rear Side I Rollover		

- Is your reason for being here today related to a current motor vehicle case? Y N (circle one)

Work

Current occupation (if retired please list previous line of work):_____

Primary work position (please circle the **ONE** you do most): STANDING SITTING LIFTING BENDING

How long is your TOTAL daily commute?_____

Is your reason for being here today related to a current worker's compensation case? Y N

SPORTS/RECREATIONAL ACTIVITIES

Please list current activities:_____

INJURIES

Please check off which injuries (if any) you have had.

☐ Broken or fractured bone Where_____ When_____

☐ Sprain or tear Where_____ When_____

☐ Concussion or Loss of Consciousness Where_____ When_____

☐ Surgery Where_____ When_____

Signature:_____ Date:_____

CHIEF COMPLAINT

- Primary reason for being here today (please list only ONE AREA):_____

  How long have you had this?_____

  Is it daily or intermittent?_____

- How would you describe your symptom? (please circle ALL that apply):

DULL ACHE STIFF BURNING NUMBNESS TINGLING STABBING SHOOTING TIGHT PRESSURE OTHER:_____

- On a scale of 0-10, how would you best rate your symptom? (With 0 being no pain and 10 being the worst pain) ____

- Does your symptom travel anywhere? (Example: into head, down arm or leg, etc.) Y N
  If yes, please explain where your symptom radiates to:_____

- Has this symptom gotten BETTER WORSE SAME since it began? (please circle ONE)

- What time of day is it worse? (please circle ONE) MORNING AFTERNOON EVENING RANDOM

- What do you do to make it feel better? (please circle ALL that apply)

  HEAT ICE STRETCH OTC MEDICATION PRESCRIPTION MED. OTHER:_____

ADDITIONAL INFORMATION

Are you or have you been in the military? Y N Branch:_____

Are you a student? Y N If yes, Grade/Year:_____

Are you (please circle ONE): RIGHT handed, LEFT handed or AMBIDEXTROUS?

What's your current stress level?: (please circle ONE) MILD MODERATE EXTREME

Who else have you seen for this issue? (Please circle ALL that apply)

Medical Doctor Naturopath Acupuncturist Homeopath Massage Therapist

Psychotherapist Reiki/ Energy Healer Dentist Physical/Occupational Therapist Other:

Signature:_____ Date:_____

Pregnancy Questionnaire

Are you pregnant? Y N

If yes, please answer the following questions.

If no, please circle N and sign and date at bottom

What is your Estimated Due Date (EDD)?:_____

Who is prenatal care provider?_____

Are you planning a HOSPITAL BIRTH CENTER or HOME BIRTH? (please circle ONE)

Do you have a doula? Y N If yes, please list who your doula is:_____

What type of childbirth class have you taken or plan to take?
(Please circle):
BRADLEY BRIO NATURAL CHILDBIRTH HYPNOBIRTHING OTHER:_____

Have you heard of the Webster Chiropractic Pregnancy Technique? Y N

Are you taking a prenatal vitamin? Y N If yes, which one?_____

Are you taking a prenatal DHA supplement? Y N If yes, which one?_____

Are you taking an iron supplement? Y N If yes, which one?_____

Are you taking a prenatal yoga or prenatal fitness class? Y N If yes, where?_____

Is your baby vertex (head down)? Y N If no, what is your baby's position?_____

Are you expecting twins? Y N

Signature:_____ Date:_____

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) concerns the security of your personal and medical information. We respect your privacy and rights, so we follow these guidelines as applicable to our practice.

A partial list of your rights includes, but is not limited to allowing (or prohibiting) health care providers from revealing information with your permission, as necessary, to others involved in your health care, such as insurance carriers, physicians, home care aides, and family members, friends, or other health care proxies who share responsibility for your wellbeing or billing services rendered.

Information includes, but is not limited to medical records, diagnostic reports, treatments, test and results, billing, and referrals, as well as personal data such as birth date, etc.

We will coordinate with all parties necessary for prompt, accurate and effective treatment and proper billing. We will gladly explain all aspects of your care to you or assigned persons as you wish.

We are required to give each patient notice of Privacy Practices (above) listing in which we might use your Protected Health Information. Please sign below, hereby stating that you have read this notice.

Privacy Policies of Healing Hands Chiropractic, LLC

I give Healing Hands Chiropractic permission to treat me in a semiprivate room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, I may schedule a private consultation with the doctor for these conversations upon my request.

Terms of Acceptance

When a patient seeks chiropractic care, and when a chiropractor accepts a patient for such care it is essential that they both be seeking the same goals. It is not the goal of this office to treat, nor cure physical, mental, or emotional ailments; nor to diagnose or give advice about such ailments.

Our only goal and intention is to keep the body as free from vertebral subluxations as we can. We do this because our absolute conviction is that every human being functions better on all levels when no subluxations are present.

I _____undertake chiropractic care at Healing Hands Chiropractic on the understanding of and agreement with the above explanation.

Release of Information

I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner(s) named above other health care professionals to whom I am referred and to the insurance carrier or any other entity responsible for payment, utilization and/or quality review for all or a portion of my care and treatments.

Patient Signature _____Date _____

If patient required assistance to complete information forms, please sign below and state your relationship to the patient.

Signature_____ Date _____ Relationship_____