Chiropractic Registration and History

Todays Date: Please Print Clearly

Patient Information

Name:_____
Street:_____
City/St./Zip_____
Home Phone _____
Cell Phone _____
Email _____
Sex_____ Height_____ Weight _____
Birthdate _____ /_____ /_____ Age _____
Marital Status_____ First Name_____
Contact Method: CELL HOME EMAIL
Who referred you to our office?

Are you or someone in your household a Veteran, Active Member of Military? Yes or No
Active member of any Police, Fire or EMS?
YES or NO

Insurance Information

Please Give card to Front Desk

Family/Household

List All Names and Ages of People in your Household

Employer Name:

Smoke? (circle one)

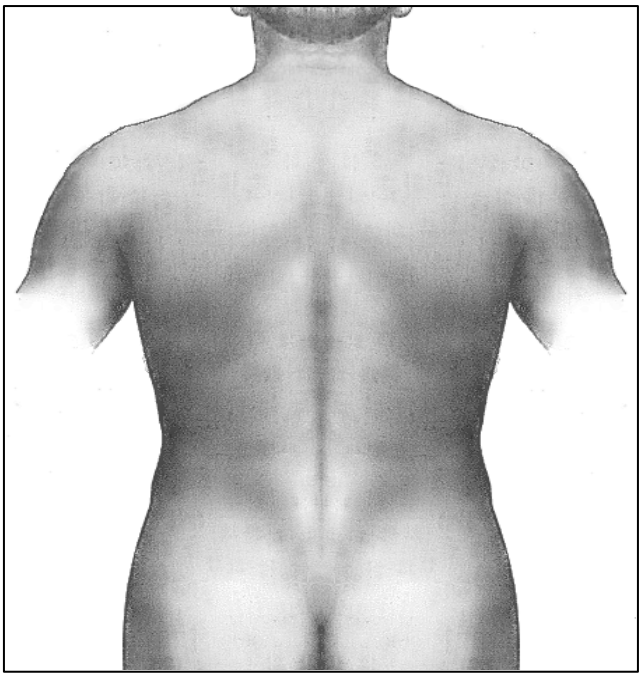
Everyday Occas Never Former

Chiropractic History

Chiropractor's Name_____
Reason_____
Date of Last Visit_____

Primary Complaints

Circle the areas where you have complaints and use the boxes to your right to describe them in order of severity



1 Location of Complaint_____
Pain Rating 1(least) to 10(worst) - _____
Date the pain started - _____
Type of Pain (choose all that apply from list below)
_____
Does it interfere with any Acts of Daily Living?
***choose all that apply from list below**
_____
List any Home Remedies you are using -
_____

2 Location of Complaint_____
Pain Rating 1(least) to 10(worst) - _____
Date the pain started - _____
Type of Pain (choose all that apply from list below)
_____
Does it interfere with any Acts of Daily Living?
***choose all that apply from list below**
_____
List any Home Remedies you are using -
_____

***Options for Acts of Daily Living**

SITTING	LYING DOWN
STANDING	WORK
WALKING	SLEEP
BENDING	ROUTINE

***Options for Types of Pain:**

SHARP	NUMBNESS/TINGLING
DULL	ACHING
THROBBING	SHOOTING
BURNING	STIFFNESS
CONSTANT	INTERMITTANT

Your Personal Health History (please check all that apply)

O Constipation	O Allergies _____	O Nervousness
O Diarrhea	O Asthma	O Parkinsons
O Loss of Bowel Contr	O Fibromyalgia	O Pinched Nerve
O Ulcers	O German Measles	O Psychological Disorder
O Arthritis	O Hepatitis	O Dementia/ Alzheimers
O Broken Bones	O Lung Disease	O Menstrual Cramps
O Dislocated Joints	O Polio	O Reproductive Disorders
O Herniated Disk	O Rheumatic Fever	O AIDS/HIV
O Osteoporosis	O Scarlet Fever	O Anemia
O Rheumatoid Arthritis	O Sinus Trouble	O Bladder Trouble
O Scoliosis	O Tuberculosis	O Epilepsy/Seizures
O Chest Pain	O Venereal Disease	O Endocrine/Hormonal Problems
O Heart Disease	O Cancer _____	O Rheumatism
O High Blood Pressure	O Tumors of Growths	O Diabetes
O High Cholesterol	O Concussion	O Other:
O Kidney Disease	O Depression	_____
O Poor Circulation	O Migraines/Headaches	O Other:
O Stroke	O Multiple Sclerosis	_____
O Clotting Disorder	O Muscular Dystrophy	O Other:_____

Exercise	Work Activity	Habits
O NONE	O SITTING	O SMOKING - PACKS/DAY_____
O MODERATE	O STANDING	O DRINKING - DRINKS/WEEK_____
O HEAVY	O HEAVY LABOR	

Accidents/Injuries (please list with dates)

_____
_____
_____

Surgeries (please list with dates)

_____
_____
_____

List All Medications you are currently taking

_____
_____
_____

Allergies (medications, etc.)

_____
_____
_____

	Illness	Type	Family Member
O	Cancer		
O	Clotting Disorder		
O	Dementia/Alzheimers		
O	Diabetes		
O	Gastrointestinal Disorder		
O	Heart Disease		
O	High Blood Pressure		
O	Kidney Disease		
O	Lung Disease		
O	Osteoporosis		
O	Psychological Disorder		
O	Septicemia		
O	Stroke		
O	Sudden Infant Death		
O	Other		

Doctor-Patient Relationship in Chiropractic/Privacy Statement

When a person seeks chiropractic care and when a chiropractor accepts a patient for such care, it's essential that they both are seeking and working towards the same goals. Chiropractic has one goal. It is therefore important that you understand the goal and our method to attain it. In this way there will be NO confusion, misunderstanding, or disappointment.

The purpose of Chiropractic is to restore and maintain the integrity of the spinal cord and its' nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine (called vertebra). Misalignments of the vertebra, which interfere with the functions of these pathways, are called SUBLUXATIONS. Subluxations come from many causes and prevent various organs, glands and tissues from functioning properly.

By means of a Chiropractic ADJUSTMENT, subluxations are corrected (reduced). Thus, the normal nerve function restores itself. The goal of Chiropractic is to adjust vertebral subluxations for the purpose of allowing the proper transmission of nerve supply over nerve pathways to every part of the body at all times.

This allows the body's inborn, innate healing ability to work to maximum efficiency. With a proper nerve supply, health improves. In some, symptoms clear up quickly. In others, the process is slower, and in some, it is only partial or not at all. Regardless of what the disease is called, the Chiropractor does not offer to heal or treat it. The Chiropractor's only goal is to allow the body to heal itself and his only means is the correction of the vertebral subluxation.

Please understand that Chiropractic is NOT a substitute for medical treatments of any kind. Also, NO statement of the chiropractor is intended as a medical diagnosis and should not be confused as such. Chiropractic is not intended to be a treatment of the symptoms of a medical condition or to treat the causes of a medical condition.

Only a chiropractor can determine if your case is a chiropractic case. Medical doctors diagnose disease and chiropractors diagnose vertebral subluxations. Your diagnosis in this clinic will reflect spinal nerve interference, which is caused by vertebral subluxations. Our doctors will work with any other health care provider for your benefit. Inversely, you should expect all other health care providers to work together with your chiropractor for your benefit. This team approach to your health care will benefit you the patient the best.

The patient, in coming to the chiropractor, gives the chiropractor permission and authority to adjust the patient for spinal subluxations. If the patient is aware of any latent pathological defects, illness or deformities, which would not otherwise come to the attention of the chiropractor, it is their responsibility to notify the chiropractor. The chiropractor, of course, will not provide chiropractic adjustments if he is aware of any such conditions. The chiropractor provides a specialized health service in the detection and correction of the vertebral subluxation and its related components. Any risks regarding chiropractic treatment will be explained, in detail, upon request.

The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the **Health Insurance Portability and Accountability Act** of 1996 ("HIPAA"). A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPPA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party. Our privacy policy is available at the front desk upon your request.

Just as in any good relationship, proper communication is an absolute necessity. We want to help you attain your goal of health. If at any time your response is not satisfactory, we will gladly assist you in choosing a referral doctor for another opinion. Your health is our number one priority.

I, ________________________, have read the above, understand it fully and undertake Chiropractic care on this basis.
(Please Print Name)
Signature ____ Date ______________

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CONSENT TO TREAT A MINOR CHILD

I hereby authorize the doctors of De Saro Chiropractic Center, and whomever they may designate as their assistants to administer treatment as they so deem necessary to ___________________________________,

Signature ____ Date ______________

De Saro Chiropractic Center
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