Middleton Chiropractic Registration and History

Natural Healing Through Chiropractic Care

PATIENT INFORMATION

Thank you for choosing our practice for your chiropractic needs. Please complete this form. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

PLEASE PRINT:

Name_____ Today's Date_____/_____/_____
First Last

Address_____ City_____ State_____

Zip Code_____ Home Phone(_____)_____

Cell Phone(_____)_____ Birthdate_____/_____/_____

SS#_____/_____/_____ Sex: Female / Male

Employer_____ Occupation_____

Work Phone(_____)_____

Who may we thank for referring you to us?_____

Below please list an individual(s) whom we are allowed to share your care information with:

Name_____ Relationship_____ Phone(_____)_____

Name_____ Relationship_____ Phone(_____)_____

In case of an emergency, whom would you like us to contact:

Name_____ Phone(_____)_____

Name_____ Phone(_____)_____

PATIENT INFORMATION

PLEASE PRINT

Patient _____ Date _____

Accident? ☐ Yes ☐ No Type: ☐ AC ☐ PI ☐ WC ☐ Other: _____

Reason for visit: _____

Date symptoms started: _____

Symptoms getting worse? ☐ Yes ☐ No ☐ Same

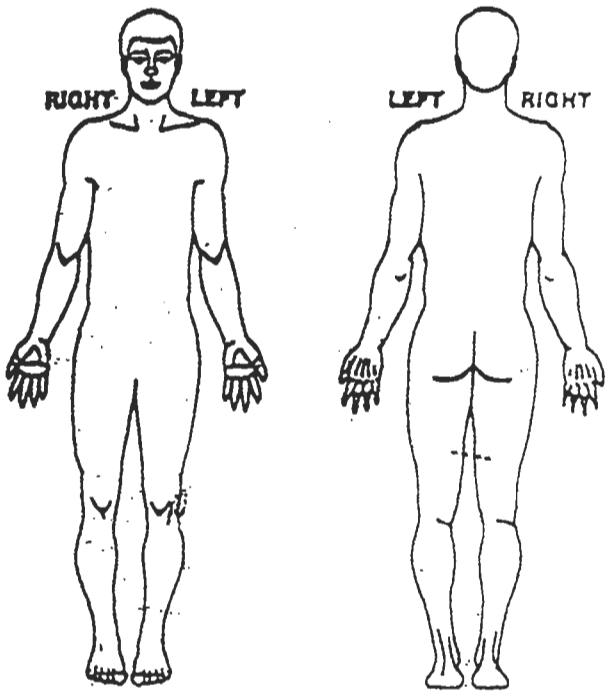
Pain Classification: ☐ Constant ☐ Intermittent ☐ Occasional
☐ A.M. ☐ P.M. ☐ Before Activity ☐ After Activity

Pain Type: ☐ Slight ☐ Mild ☐ Moderate ☐ Severe ☐ Burning
☐ Sharp ☐ Throbbing ☐ Tingling ☐ Dull ☐ Aching
☐ Shooting ☐ Cramping ☐ Stiffness ☐ Swelling
☐ Numbness ☐ Stabbing ☐ Other _____

Pain Interferes with: ☐ Sleep ☐ Daily Routine ☐ Work ☐ Recreation

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

Mark an X on the picture where you
continue to have pain, numbness, tingling.



Helps	Position	Hurts
☐	Bending Backward	☐
☐	Bending Forward	☐
☐	Bending Leg R L B	☐
☐	Driving	☐
☐	Lifting	☐
☐	Lying Face Down	☐
☐	Lying on Back	☐
☐	Lying on Side	☐
☐	Sitting	☐
☐	Standing	☐
☐	Stretching	☐
☐	Turning Body R L B	☐
☐	Turning Head R L B	☐
☐	Walking	☐
☐	Other: _____	

PATIENT NAME _____ CASE NO. _____ DATE _____

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medication ☐ 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:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV	☐	☐	Diabetes	☐	☐	Measles	☐	☐	Rheumatoid Arthritis
☐	☐	Alcoholism	☐	☐	Emphysema	☐	☐	Migraine Headaches	☐	☐	Rheumatic Fever
☐	☐	Allergy Shots	☐	☐	Epilepsy	☐	☐	Miscarriage	☐	☐	Scarlet Fever
☐	☐	Anemia	☐	☐	Fractures	☐	☐	Mononucleosis	☐	☐	Stroke
☐	☐	Anorexia	☐	☐	Glaucoma	☐	☐	Multiple	☐	☐	Suicide Attempt
☐	☐	Appendicitis	☐	☐	Goiter	☐	☐	Sclerosis	☐	☐	Thyroid Problems
☐	☐	Arthritis	☐	☐	Gonorrhea	☐	☐	Mumps	☐	☐	Tonsilitis
☐	☐	Asthma	☐	☐	Gout	☐	☐	Osteoporosis	☐	☐	Tuberculosis
☐	☐	Bleeding Disorders	☐	☐	Heart Disease	☐	☐	Pacemaker	☐	☐	Tumors, Growths
☐	☐	Breast Lump	☐	☐	Hepatitis	☐	☐	Parkinson's Disease	☐	☐	Typhoid Fever
☐	☐	Bronchitis	☐	☐	Hernia	☐	☐	Pinched Nerve	☐	☐	Ulcers
☐	☐	Bulimia	☐	☐	Herniated Disk	☐	☐	Pneumonia	☐	☐	Vaginal Infections
☐	☐	Cancer	☐	☐	Herpes	☐	☐	Polio	☐	☐	Venereal Disease
☐	☐	Cataracts	☐	☐	High Cholesterol	☐	☐	Prostate Problem	☐	☐	Whooping Cough
☐	☐	Chemical Dependency	☐	☐	Kidney Disease	☐	☐	Prosthesis	☐	☐	Other _____
☐	☐	Chicken Pox	☐	☐	Liver Disease	☐	☐	Psychiatric Care	☐	☐	_____

EXERCISE

☐ None ☐ Moderate ☐ Daily ☐ Heavy

WORK ACTIVITY

☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Are you pregnant? ☐ Yes ☐ No Due Date _____

INJURIES / SURGERIES you have had, please describe.

Falls _____ Date _____

Head Injuries _____ Date _____

Broken Bones _____ Date _____

Dislocations _____ Date _____

Surgeries _____ Date _____

MEDICATIONS

_____

_____

Pharmacy Name _____

Pharmacy Phone _____

ALLERGIES

_____

_____

_____

_____

VITAMINS / HERBS / MINERALS

_____

_____

_____

_____

PATIENTS RIGHTS AND RESPONSIBILITIES STATEMENT

STATEMENT OF PATIENTS RIGHTS:

-Patients have the right to be treated with dignity and respect.
-Patients have the right to fair treatment regardless of race, religion, gender, ethnicity, age, disability or type of payment.
-Patients have the right for privacy of their treatment and other patient information given.
-Only in an emergency, or if required by law, are records to be released without member permission.
-Patients have the right to information from staff/providers in language that they can understand.
-Patients have the right to have an easy to understand explanation of their condition and treatment.
-Patients have the right to know all about their treatment choices, no matter of cost or if they are covered or not.
-Patients have the right to get information about services and their role in the treatment process.
-Patients have the right to provider information.
-Patients have the right to know clinical guidelines used in providing and/or managing their care.
-Patients have the right to provide input on policies and services.
-Patients have the right to know about the complaint, grievance and appeal process.
-Patients have the right to know about State and Federal laws that relate to their rights and responsibilities.
-Patients have the right to know of rights and responsibilities in the treatment process.
-Patients have the right to share in the information of their care plan.

STATEMENT OF PATIENTS RESPONSIBILITIES:

-Patients have the responsibility to give provider information needed. This is so the best possible care is achieved.
-Patients have the responsibility to let providers know when the treatment plan no longer works for them.
-Patients have the responsibility to follow their medical plan. They must tell of medical changes.
-Patients have the responsibility to treat those giving care with dignity and respect.
-Patients should not take actions that could harm providers, insurance employees or other patients.
-Patients have the responsibility to keep appointments. They should call ASAP to cancel visits.
-Patients should ask providers about their care so they can understand the care and their role in the care.
-Patients have the responsibility to let the provider know about problems with paying fees.
-Patients are responsible to follow the plan/instructions for their care which should be mutually agreed upon.

Signature_____ Date:_____