Chiropractic Registration & History

Patient Information

Date_____ Male / Female

Name_____

Address_____

City_____State_____Zip_____

Birthdate_____Age_____

Marital Status: Single Married Widowed Divorced

Social Security # _____

Occupation_____

Employer_____

Spouses Name_____

Spouses Employer_____

Whom May We Thank For Referring You?

Phone Numbers

Home_____Fax_____
Work_____Ext_____
Cell_____Spouse_____
Email_____

Insurance

A superbill will be provided upon request for you to submit to your insurance company for reimbursement directly to you. This method is used to help keep health care costs low.

Medicare #_____

Supplemental Policy_____
Policy #_____

I understand that I am financially responsible for all charges. I hereby authorize the doctor to release all information regarding my records if needed.

Accident Information

Is condition due to an accident? Yes No
Type of Accident: Auto Home
Other Work

Patient Condition

☐ **Please check if you are here for Wellness Care.**

Reason for Visit_____

When did your symptoms appear?_____

Is your condition getting progressively worse?_____

Put an "X" on the picture where you have pain, numbness or tingling.

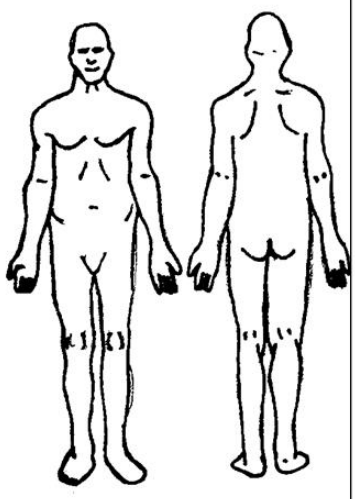
Rate the severity of your condition: 0 (least) to 10 (worst) _____

Type of pain: Sharp-Dull-Burning-Throbbing-Numbness-Cramping

Frequency of pain: Constant or Come and go

Does it interfere with: Work Sleep Daily Routine Recreation

Activities that are most painful_____



Health History

What type of care have you already received for your condition? ○ Chiropractic ○ Massage ○ Medication ○ Surgery ○ Other _____

Names of other Doctor(s) who have cared for you:_____

Last Date of Spinal Examination, X-ray, MRI,CT, or Bone Scan_____

Please **circle** any conditions you **currently** suffer from, and **check** ✓ any that you **previously** have had.

AIDS/HIV	Alcoholism	Allergy Shots	Anemia	Anorexia
Appendicitis	Arthritis	Asthma	Bleeding	Breast Lump
Bronchitis	Bulimia	Cancer	Cataracts	Chemical Dependent
Chicken Pox	Diabetes	Emphysema	Epilepsy	Fractures
Glaucoma	Goiter	Gonorrhea	Gout	Heart Disease
Hepatitis	Hernia	Herniated Disc	Herpes	High Cholesterol
Kidney Disease	Liver Disease	Measles	Headaches	Miscarriage
Mono	MS	Mumps	Osteoporosis	Pacemaker
Parkinson's	Pinched Nerve	Pneumonia	Polio	Prostate problem
Prosthesis	Psychiatric care	Rheumatoid Arth	Rheumatic fever	Scarlet fever
Stroke	Suicide attempt	Thyroid problem	Tonsillitis	TB
Tumors, growths	Typhoid fever	Ulcers	Vaginal infections	Venereal disease
Whooping cough	Colds	Flu	Viral infections	Vision problems
Fibromyalgia	Migraines	Other_____		

Exercise

None
Moderate
Daily
Extreme Sports
Weight Lifting
Other_____

Work Activity

Sitting_____Hrs/Day
Standing_____Hrs/Day
Lt Labor_____Hrs/Day
Hvy Labor____Hrs/Day
Other_____
_____

Habits

Smoking Packs/Day_____
Alcohol Drinks/Week_____
Coffee/Caffeine Cups/Day_____
High Stress Level Reason_____
_____
Other_____

For Women Only: Are you pregnant? Yes No Due Date_____ Last menstrual period_____

Injuries/Surgeries

	Description	Date
Falls		
Head Injuries/Whiplash		
Broken Bones/Dislocations		
Surgeries		
Cancer		

Medications/Vitamins/Herbs/Minerals

Please list all meds, vitamins, and supplements currently taking:_____
_____

I hereby authorize the doctor, and/or his associates to examine me, and to perform and necessary diagnostic procedures, including X-ray to fully evaluate my condition for the presence of vertebral subluxation.

Patient Signature_____ **Date**_____

Trauma History Form

When was your most recent auto accident (you may not have been driving)? _____ Speed? _____ Front, side or back collision? _____ Did you seek Chiropractic care? Yes or No

When was the auto accident just before that? _____ Speed? _____
Front, side or back collision? _____ Did you seek Chiropractic care? Yes or No

When was the auto accident just before that? _____ Speed? _____
Front, side or back collision? _____ Did you seek Chiropractic care? Yes or No

---

Most people have had a slip, strain, twist, or fall at work, whether it was reported or not.
When was your most recent stress or strain at work? _____ Did you seek Chiropractic care? Yes or No

When was the stress or strain at work just before that? _____ Did you seek Chiropractic care? Yes or No

When was the stress or strain at work just before that? _____ Did you seek Chiropractic care? Yes or No

---

What type of sports or recreational activities do you do? _____
_____
When was your most recent stress or strain while doing that activity? _____ Did you seek Chiropractic care? Yes or No

When was the stress or strain right before that while doing that activity? _____ Did you seek Chiropractic care? Yes or No

When was the stress or strain right before that while doing that activity? _____ Did you seek Chiropractic care? Yes or No

---

What accident occurred at home or elsewhere that you haven't mentioned yet? _____
_____
Did you seek Chiropractic care? Yes or No

Any other kind of stress: mental, physical or spiritual that you haven't mentioned yet? __
_____

What is your ultimate goal for visiting this office? _____
_____
_____

Informed Consent to Chiropractic Care

Patient: Please discuss any questions or concerns with the doctor before signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the below named minor in which I am legally responsible for) by Dr. Shane Hand, his staff, and/or his associates.

The Nature Of The Chiropractic Adjustment

I will use my hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "pop" your knuckles. You may feel a sense of movement.

The Material Risks Inherent In The Chiropractic Adjustment

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strains, and stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The Probability Of Those Risks Occurring

Fractures are very rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided, we look for risk factors and will perform tests to identify if you may be susceptible to that kind of injury if necessary. The other complications are also generally described as "rare".

Ancillary Treatment

In addition to chiropractic adjustments, you may be given home instructions to use the following treatments, with the associated risks:

Heat ~ risk of 1st and 2nd degree burns, hemorrhage
Cryotherapy (cold packs) ~ risk of skin reactions
Trigger Point Therapy ~ risk of bruising, release of emboli
Massage ~ risk of deep vein thrombosis

The Availability And Nature Of Other Treatment Options

Other treatment options for your condition may include:

Self-administered over-the-counter analgesics and rest
Medical care with prescription drugs
Hospitalization
Surgery

The Material Risks Inherent In Such Options And The Probability Of Such Risks Occurring Include:

Overuse of over-the-counter medications produces undesirable side effects. If complete rest in impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his/her pain tolerance, and self discipline is not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain killers can produce undesirable effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort; his/her pain tolerance, self-discipline in not abusing the medicine, and proper professional supervision.

Hospitalization in conjunction with other care bears the additional risks of exposure to communicable disease, iatrogenic (doctor induced) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, all those of hospitalization, and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The Risks And Dangers Attendant To Remaining Untreated

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had all my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. I acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given.

Date: _____

_____

Printed Name of Patient

_____

Signature of Patient

Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alternation of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. ***OUR ONLY PRACTICE OBJECTIVE*** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

_____ _____

Signature Date