CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

SS/HIC/Patient ID#_____

Patient Name: _____

_____

Address _____

City_____

State_____ Zip _____

Email_____

Sex ☐M ☐F Age_____

Birthdate _____

☐ Married ☐ Single ☐ Widowed ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years.

2 AUTHORIZATION FOR CARE, FINANCIAL ARRANGEMENT &

Consent to treat and Financial Agreement

I do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, order diagnostic X-rays, order laboratory tests, and any treatment that in their judgment deemed advisable or is required, but not limited to adjustments to the spine and extremities, as well as any physiotherapy required for my condition, including but not limited to muscle work, electrical modalities and exercise. I understand that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, strokes, disk injuries, dislocations and sprains and strains. I do not expect the doctor to be able to explain and anticipate all risks and complications. I wish to relay to the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then best known, is in my best interest. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all bills incurred at this office. I understand that all payments are due on the day when services are rendered. The Doctor will be aware but will not be held responsible for an y pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Cancellation Policy

I also understand that the doctor's time is extremely valuable, and the numbers are available patient slots for a given day are limited and thus a 24 hour cancellation policy is strictly enforced. By signing below I agree to abide by the 24 hour cancellation policy which states that – Notice of at least 24 hours is required for cancellation. Should you cancel later than 24 hours before your intended appointment, we reserve the right to retain 50% of the normal fee due. If you fail to cancel altogether, you will be responsible for the entire fee.

Consent to Treat a Minor

I (we) being the parent (s), guardians(s) or custodian(s) of the minor _____, Age _____, do hereby authorize, request, and direct this office, it's doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor child is under care of this office's doctors and stuff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for the payment of them. I (we) hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

Privacy Policy

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Dr Buckle's "NOTICE OF PRIVACY PRACTICES"

3 PHONE NUMBERS

Cell Phone (___)_____ Home Phone (____)_____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

4 ACCIDENT INFORMATION

Is condition do to an accident? ☐ Yes ☐ No Date _____

Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

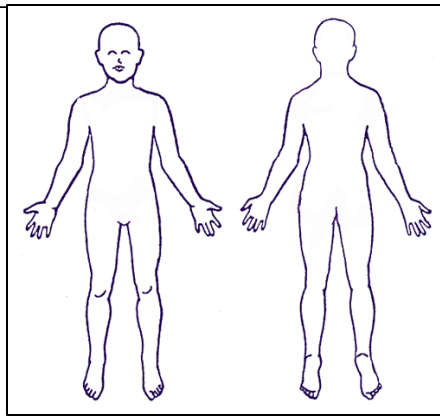
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

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



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

Type of pain: Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

What Treatments have you already received for your condition? Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and addresses 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:

AIDS/HIV	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No

EXERCISE	**WORK ACTIVITY**	**HABITS**	
☐ None	☐ Sitting	☐ Smoking	Packs/Day_____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____

Date of last Menstrual cycle: _____ (circle) **Regular/Irregular** **Date of last OB/GYN exam**: _____ (circle) **Normal/Abnormal**

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____

MEDICATIONS		**ALLERGIES**	**VITAMINS/HERBS/MINERALS**
MEDICATION TYPE/NAME	FOR WHAT CONDITION		
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____