Patient Registration

Today's Date: ___/___/___

Whom can we thank for referring you? _____

□ **Family** □**Friend** □ **Ad** □ **Co-Worker** □ **Close to home/work** □ **Doctor** □ **Insurance Plan**

Personal Information

First:_____**Middle:**_____ **Last:**_____ **Sex:Male/Female**

Address:_____**Apt #**_____

City:_____**State:**_____**Zip:**_____

Home Phone: (_____**)**_____**-**_____ **Cell Phone:(**_____**)**_____**-**_____

Best time to call:_____ **Best number to use: □ home □ cell □ other**_____

May we leave a message? □ Home Phone □ Cell Phone

Status: □ Single □ Married □ Divorced □ Separated Birth Date: ____/____/____ Age:___

Email Address:_____

Employment Information

Employer:_____ **Occupation:**_____

Business Address:_____ **Business Phone: (**_____**)**_____**-**_____

Type of Work (ex. Manual Labor, Desk ect):_____

Emergency Contact

Name:_____ **Phone Number: (**_____**)**_____**-**_____

Address: _____

Relationship: □ Spouse □ Relative □ Friend □ Other _____

Health History

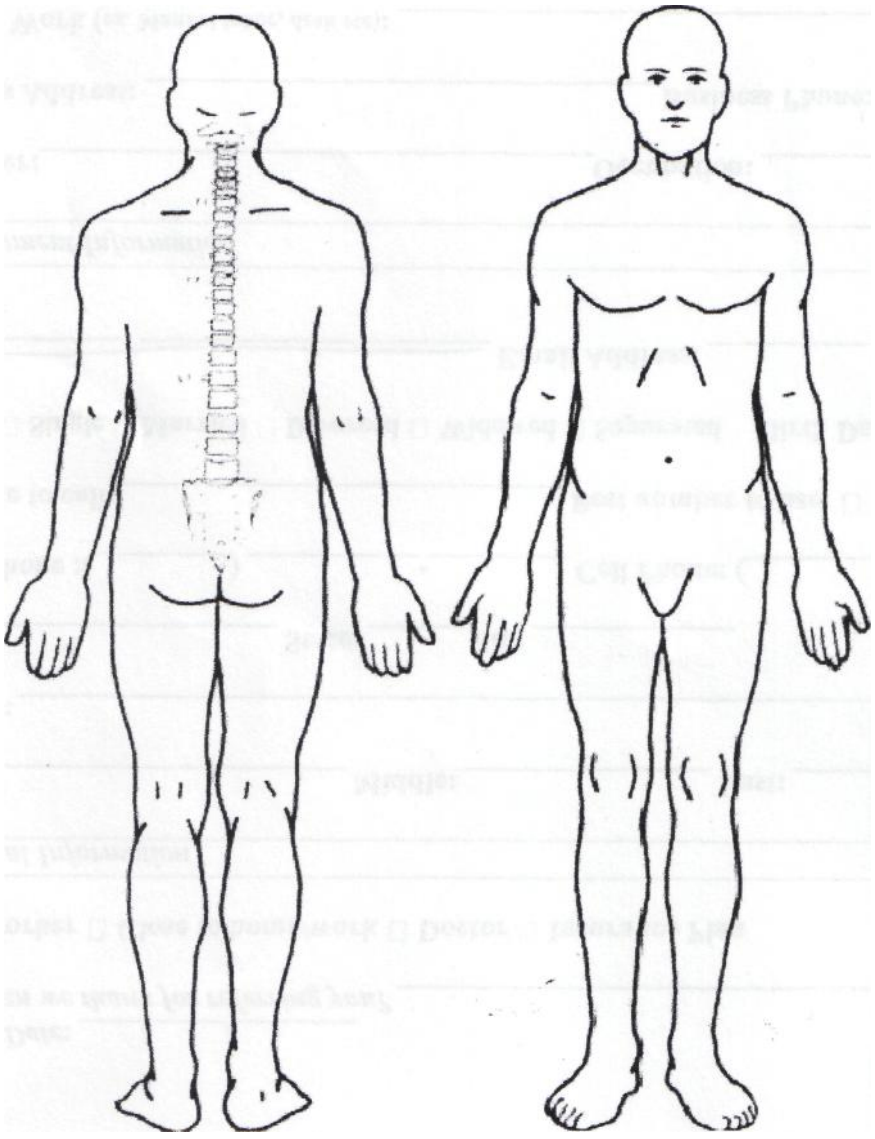
Please describe what brought you into the office today _____
_____
_____

On a scale of 1-10, 1 being “No pain or discomfort,” 6 being “Pain that limits my work schedule,” and 10 being “Pain that causes thoughts of suicide” how would you rate your pain:

NOW: _____ /10 At its WORST:_____ /10 At its BEST:_____ /10 AVERAGE: _____ /10

On the following picture, please mark the areas on your body where you feel pain or other issues.
Please use the key below to describe the type of pain.

A - Ache **B** - Burning **N** - Numbness **S** - Stabbing **T** - Throbbing **P** - Pins & Needles



If you have no pain please check here: _____

What needs to happen for you to consider your treatment plan a success?_____
_____
_____
_____
_____
_____

Have you ever consulted a Chiropractor before? Y N

If yes, who?_____
_____

When? _____

Why? _____

For how long? _____

When was the last time any of the following tests were ordered?

X-rays_____

MRI_____

Blood panel_____

Other _____

History

When did your primary complaint begin?_____

Has it ever occurred before? □ **Yes** □ **No** **When?**_____

Is this Condition: □ **Auto Related** □ **Job Related** □ **Home Injury** □ **Slip or Fall**

□ **Lifting** □ **Slept Wrong** □ **Unknown Cause** □ **Other**

Explain:_____

_____

Have you seen other doctors for this condition? □ **Yes** □ **No** **If Yes, Who?**

_____

List any motor vehicle accidents:_____

_____

List any broken bones or dislocations: _____

_____

List any hospital stays/surgeries: _____

_____

Do you now, or have you ever suffered from: (please mark "N" for now or "P" for past)

____Neck Pain	___ Low Back Pain	____Headaches	____ Dizziness
____Asthma	___Diabetes	____Arthritis	____ High Blood Pressure
____Allergies	___Lung problems	____Neuritis	____ High Cholesterol
____Depression	___Mood Disorder	____Irritability	____ Menstrual Pain/Difficulty
____Heart Burn	___ Heart trouble	____Poor Circulation	____ Sinus trouble
____Cancer	___ Nervousness	____Anemia	____ Digestive disorder
____Anxiety	___Trouble Sleeping	____Tumor	____ Numbness in Hands/Feet
____Low Energy	___Tire Easily	____TB	____ Tingling in Hands/Feet

Has anybody in your immediate family (last two generations) had any of the following conditions? Please indicate relationship.

Diabetes_____ **Stroke**_____ **Kidney Problems**_____

Heart Problems_____ **Cancer**_____ **Obesity**_____

Headaches_____ **Other:**_____

I am interested in the following:

__ Decreasing Pain __ Improving Balance __ Improving Posture
__ Increasing Strength __Changing Weight __ Improving Diet
__ Improving Flexibility __ Improving Overall Health

Do you use tobacco? Y N Have you ever? Y N How many packs per day? _____

How many servings of soda do you drink per day? __ 0 __ 1-2 __ 3-4 __>5

How many servings of coffee do you drink per day? __ 0 __ 1-2 __ 3-4 __>5

How many servings of alcohol do you drink per day? __ 0 __ 1-2 __ 3-4 __>5

How many glasses of water do you drink per day? __ 0 __ 1-2 __ 3-4 __>5

How many hours per day do you spend:
Driving: ___ <1 __1-3 ___ 3-5 __ >5

TV: ___<1 __ 1-3 __ 3-5 __ >5

Computer: ___ <1 __1-3 ___ 3-5 __ >5

How many servings of each of the following foods do you eat per day?
Veggies: ___<1 __ 1-3 __ 3-5 __ >5 Meat: ___ <1 __1-3 ___ 3-5 __ >5

Fruits: ___<1 __ 1-3 __ 3-5 __ >5 Dairy: ___ <1 __1-3 ___ 3-5 __ >5

Carbs: ___<1 __ 1-3 __ 3-5 __ >5 Sweets: ___ <1 __1-3 ___ 3-5 __ >5
(Breads & Pastas)

Do you drink diet sodas or eat sugar-free food? Y N

List all medications and supplements you are currently taking:_____

_____

Do you exercise? Y N How long do your workouts last? _____

How often do you exercise? __ >5x/week __3-4x/week __ 1-2x/week __ <1x/week

What do you do while exercising? (mark all that apply)

__ Running ___Swimming __ Abs __ Stretching/flexibility
__Walking ___Yoga/Pilates __Weight lifting __ Resistance bands
__ Stairs ___Group classes __ Other: _____

Welcome to our practice.

Our Privacy Practices

In our office, by law, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your health information to:

• Treat you • Collect payment • Run our office • Inform you about other services
• Discuss your case with family • Include you in care classes • Thank other patients for referring you

We may use your health information for:

•Health and safety reasons • Reporting to law officials • Reporting victims of abuse • Court hearings and filings
• Reporting to worker's compensation

You have the right to:

• Request a copy of your health record (an additional fee may be involved) • Request a list of whom we share your health information with • Ask us to limit the information we share • Advise our management if you believe your privacy rights have been violated
• Request confidential communications • Amend your protected health information

These privacy practices are currently in effect.

• Our office abides by the terms of the Notice currently in effect. Our office has the right to change the terms of your Notice and to make the new Notice provisions effective for all your health information that you maintain. If we change our Notice, you will be informed of the revised Notice during your next office visit.

For further information please contact our office at 215-579-9200.

What to expect:

Consultation & Exam: On your first visit, the doctor will collect some confidential health information and then sit and speak with you. After learning more about your condition, s/he will perform some preliminary screening tests. If s/he believes that s/he may be able to help you, s/he may recommend a complete examination so s/he can thoroughly evaluate your condition. You will always be informed of associated fees before any procedure or service is performed.

Report of Findings: Patients that are examined will receive a report of our findings from the recorded history, consultation, and examination. If the doctor believes s/he can help you, s/he will accept your case at this time. If s/he believes that you will not respond to his/her care, s/he will not accept your case and may refer you to another provider.

Treatment Plan: If the doctor accepts your case, s/he may recommend treatment options based on your unique needs and then an individualized treatment plan may be created to address your short- and/or long-term goals. As you advance through treatment, periodic progress evaluations will measure and compare your improvements.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me.
- I understand the purpose of today's visit.
- If the doctor believes I may respond to their care, additional services may be recommended and I will be advised of applicable cost.
- I request the service mentioned above.

_____

Print Patient or Guardian Name

_____

Patient or Guardian Signature

Date:_____

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.
There are some risks that may be associated with treatment, in particular you should note:

a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment.

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:
a. The condition that the treatment is to address;
b. The nature of the treatment;
c. The risks and benefits of that treatment; and
d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I hereby request and consent to the performance of chiropractic adjustments, physical therapy modalities, and other chiropractic procedures by the doctor, assistants, and/or designated staff who now or in the future may practice in the Newtown Health & Wellness Center.

_____ _____

Patient signature (or Legal Guardian) Signature of Witness

Print Name:_____ Print Name:_____
Date:_____ Date:_____