



CHIROPRACTIC REGISTRATION AND HISTORY

Type right into this form, then press **Submit** on the last page to email it to us. Prefer paper? Print it and bring it to your first visit.

1 PATIENT INFORMATION

Date

SS/HIC/Patient ID #

Last name

First name Middle initial

Address

E-mail

City

State Zip

Sex ☐ M ☐ F Age Birthdate

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for years

Patient employer/school

Occupation

Employer/school address

Employer/school phone

Spouse's name

Spouse's birthdate SS#

Spouse's employer

Whom may we thank for referring you?

3 PHONE NUMBERS

Cell phone Home phone

Best time and place to reach you

IN CASE OF EMERGENCY, CONTACT

Name Relationship

Home phone Work phone

2 INSURANCE INFORMATION

Who is responsible for this account?

Relationship to patient

Insurance company

Group #

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's name

Birthdate SS#

Relationship to patient

Insurance company

Group #

ASSIGNMENT AND RELEASE

Insurance company(ies)

Assign benefits to Dr.

I certify that I and/or my dependent(s) have insurance coverage with the insurance company(ies) named above, and I assign directly to the doctor named above all insurance benefits, if any, otherwise payable to me for services provided. I understand that I am financially responsible for all charges, whether or not they are paid by insurance. I authorize the use of my signature on all insurance submissions. The doctor named above may use my health care information and may share it with the insurance company(ies) named above and their agents to obtain payment for services and to determine my insurance benefits. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of patient, parent, guardian or personal representative (type full name)

Printed name of patient, parent, guardian or personal representative

Date Relationship to patient

4 SPORTS INJURY

Is your condition due to a sports injury? ☐ Yes ☐ No

Date of injury Sport or activity

How did it happen?

Seen by: ☐ Athletic trainer ☐ Physical therapist ☐ Doctor/ER

Are you still playing or training? ☐ Yes ☐ Limited ☐ No



5 PATIENT CONDITION

Reason for visit

When did your symptoms appear? Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Where do you continue to have pain, numbness or tingling? Check all that apply.

- | | | | | | |
|--|---|---|--|--|---|
| ☐ Head | ☐ Neck | ☐ Jaw | ☐ Upper back | ☐ Mid back | ☐ Low back |
| ☐ Left shoulder | ☐ Right shoulder | ☐ Left arm/elbow | ☐ Right arm/elbow | ☐ Left wrist/hand | ☐ Right wrist/hand |
| ☐ Left hip | ☐ Right hip | ☐ Left leg/knee | ☐ Right leg/knee | ☐ Left ankle/foot | ☐ Right ankle/foot |

Other area(s)

Rate the severity of your pain from 1 (least pain) to 10 (severe pain): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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

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

How often do you have this pain?

Is it constant or does it come and go?

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ 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

EXERCISE

- ☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

- ☐ Sitting
☐ Standing
☐ Light labor
☐ Heavy labor

HABITS

- ☐ Smoking
☐ Alcohol
☐ Coffee/caffeine drinks
☐ High stress level

Packs/day

Drinks/week

Cups/day

Reason



6 HEALTH HISTORY (CONTINUED)

Mark Yes or No to tell us if you have had any of the following:

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV	☐	☐	Diabetes	☐	☐	Liver disease	☐	☐	Rheumatic fever	☐	☐
Alcoholism	☐	☐	Emphysema	☐	☐	Measles	☐	☐	Rheumatoid arthritis	☐	☐
Allergy shots	☐	☐	Epilepsy	☐	☐	Migraine headaches	☐	☐	Scarlet fever	☐	☐
Anemia	☐	☐	Fractures	☐	☐	Miscarriage	☐	☐	Sexually transmitted disease	☐	☐
Anorexia	☐	☐	Glaucoma	☐	☐	Mononucleosis	☐	☐	Stroke	☐	☐
Appendicitis	☐	☐	Goiter	☐	☐	Multiple sclerosis	☐	☐	Suicide attempt	☐	☐
Arthritis	☐	☐	Gonorrhea	☐	☐	Mumps	☐	☐	Thyroid problems	☐	☐
Asthma	☐	☐	Gout	☐	☐	Osteoporosis	☐	☐	Tonsillitis	☐	☐
Bleeding disorders	☐	☐	Heart disease	☐	☐	Pacemaker	☐	☐	Tuberculosis	☐	☐
Breast lump	☐	☐	Hepatitis	☐	☐	Parkinson's disease	☐	☐	Tumors, growths	☐	☐
Bronchitis	☐	☐	Hernia	☐	☐	Pinched nerve	☐	☐	Typhoid fever	☐	☐
Bulimia	☐	☐	Herniated disk	☐	☐	Pneumonia	☐	☐	Ulcers	☐	☐
Cancer	☐	☐	Herpes	☐	☐	Polio	☐	☐	Vaginal infections	☐	☐
Cataracts	☐	☐	High blood pressure	☐	☐	Prostate problem	☐	☐	Whooping cough	☐	☐
Chemical dependency	☐	☐	High cholesterol	☐	☐	Prosthesis	☐	☐	Other		
Chicken pox	☐	☐	Kidney disease	☐	☐	Psychiatric care	☐	☐			

Are you pregnant? ☐ Yes ☐ No Due date

Injuries/surgeries you have had

Description

Date

Falls

Head injuries

Broken bones

Dislocations

Surgeries

7 MEDICATIONS, ALLERGIES, VITAMINS/HERBS/MINERALS

MEDICATIONS

Pharmacy name

Pharmacy phone

ALLERGIES

VITAMINS/HERBS/MINERALS



INFORMED CONSENT FOR CHIROPRACTIC CARE

PATIENT

I hereby request and consent to performance of the procedures within the scope of Chiropractic including, but not limited to, adjustments, X-ray procedures, and various forms of physical therapy and supplementation from the Doctors of Chiropractic associated with, employees of assistants employed by the Doctors, or Chiropractors filling in for any Doctors listed in the practice listed above.

Someone from the above practice has discussed and I understand the nature and purpose of Chiropractic adjustments and other therapies used at Erickson Chiropractic and Wellness. I understand and have been informed that there are some risks involved in Chiropractic treatments such as, but not limited to, the possibility of: fractures, disc injury, strokes, dislocations, and sprains. I wish to rely on the Doctors knowledge and judgement during the course of the procedures now and in the future as long as I am under care at this practice, which the Doctor feels at the time, based on the facts known is in the best interest of me.

I have read, or have had the above consent information read to me, and have had the opportunity to ask any questions to clarify the content, and by signing below, I agree to the named procedures. I intend this content form to cover the entire course of treatment for my present condition and for any conditions in the future.

Signature of patient (type full name)

Date

Witnessed by (office use)

Date



NOTICE OF PRIVACY FOR PATIENTS PROTECTED HEALTH INFORMATION

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy. This office uses and discloses your protected health care information for the following reasons:

- To share with other treating healthcare providers regarding your health care.
- To submit to Medicare to verify that treatment has been rendered.
- To determine patient's benefits in a Medicare plan.
- Releasing information required by State or Federal public Health Law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for your privacy have been attained.
- Emergency situations
- Abuse, neglect or domestic violence
- Appointment reminders to household members or answering machines

Any other uses or disclosures will only be made with your specific written prior authorization.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Inspect, copy and amend your protected health information as allowed by law.
- To render a complaint to our privacy officer or the Secretary of Health and Human Services

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

Patient signature (type full name)

Date



OFFICE COPY

Insurance: Although we are in-network preferred providers for most health insurance companies, your policy is ultimately your responsibility. Your insurance is a contract between you and your insurance company. There are many different policies that exist. Due to issues with verification of insurance coverage, we prefer not be held accountable for what your insurance covers and does not cover. Most times we have verified this insurance with 100% accuracy; however problems have arisen in the past. Our office will notify you when we think there is a policy that we do not understand.

Initial I have read and understand that my insurance is ultimately my responsibility.

Appointments:

Currently we set standard office visits at 3 people in each 30 minute time slot. These times are reserved specifically for you. If you have an appointment set, nobody else is allowed to schedule at that time. If you do not make your appointment, this ends up being a time when someone else may have wanted that time, but was unavailable because we were holding it for you. We strive to respect your time as much as possible by seeing you at your scheduled appointment time. It is appreciated that you respect our time as well. Our office policy states you should give 24 hours notice to reschedule appointment. If your appointment is less than 24 hours away, please call us as soon as possible if you need to cancel or move your appointment. Most times if you call within a few hours of your appointment to cancel the appointment, the doctor will approve a waiver on your missed appointment fee up to a max of 2 times.

If you are late for an appointment, you risk being seen after people who made their appointment and were on time.

If the above criteria are not met, a **\$50.00** charge will be billed to your account and must be paid directly from you (this will not be billed to insurance, personal injury, or workman's compensation cases.) If you discontinue care at this office, a bill will be mailed to you for this fee. If this bill is not paid within 30 days, we will be prompted to send you to collections.

Printed name	Date
Signature (type full name)	
Witness (office use)	Date

All done?

Submit by email

Pressing **Submit by email** opens a new email to **info@ericksonchiropracticandwellness.com** with this completed form attached — then just press Send. It works in Adobe Acrobat or the free Acrobat Reader on a computer.

On a phone, or using Chrome, Safari or Preview? Save the completed form and email it to info@ericksonchiropracticandwellness.com, or print it and bring it to your first visit. Questions? Call (706) 353-7778.