Patient History and Registration

BRINSON

FAMILY CHIROPRACTIC

Name: _____

Date: _____

Patient Condition

Reason for Visit / Primary Complaint: _____

When did this symptom begin? _____

Does the discomfort from this symptom seem to be getting worse? _____

On a scale of 1-10 (10 being worse), How would your rate your pain? _____

Is this from injury, if yes: _____

Health History

Mark if you have had any of the following:

- ☐ Headaches / Migraines
- ☐ Neck Pain and Stiffness
- ☐ Jaw Pain / TMJ
- ☐ Upper or Mid-Back Pain/Stiffness
- ☐ Shoulder Pain
- ☐ Elbow/Arm/Hand Pain
- ☐ Low Back Pain
- ☐ Hip / Leg / Knee Pain
- ☐ Tingling/Numbness
- ☐ Memory Loss
- ☐ Dizziness / Fainting
- ☐ Ringing in Ears
- ☐ Ear Infections
- ☐ Foot/Ankle Pain
- ☐ Sinus Trouble
- ☐ Shortness of Breath
- ☐ Anxiety / Depression
- ☐ Difficulty Sleeping
- ☐ Fatigue /Tiredness
- ☐ Nausea
- ☐ Diarrhea / Constipation
- ☐ Other Digestive Trouble
- ☐ Cold Hands/Feet
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Fibromyalgia
- ☐ Diabetes / Hypoglycemia

What have you tried already? Medicine Surgery Physical Therapy Chiropractic Nothing Other

Name and Phone Number or Medical Doctor: _____

Please let the date of last:

Physical Exam _____ Spinal Exam _____ Blood Test _____

Chest X-ray _____ Spinal X-Ray _____ Urine Test _____

Dental X-ray _____ MRI / CT / Bone Scan _____

For Women: Are you Pregnant? Yes No Due Date _____

For Women: What is the date of your last Mammogram? _____

Injuries and Surgeries

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Hospitalizations _____

Surgeries _____

Have you ever been involved in a motor vehicle accident? If yes, please describe: _____

_____

Medications (Please list all)

_____

_____

_____

Allergies (Please list all)

_____

_____

_____

Lifestyle (circle all that apply)			Vitamins and Supplements (Please list all)
Exercise	*Work*	*Habits*	
None	Sit	Smoke	
Moderate	Stand	Alcohol	
Daily	Light Labor	Coffee / Caffeine	
Heavy	Heavy Labor	High Stress	

Patient Information

Personal Information

Date of Birth _____
Address: _____
City/State/Zip Code: _____
Home Phone: ( ) _____
Work Phone: ( ) _____
Cell Phone: ( ) _____
Mobile Carrier: _____
Email: _____
Soc. Sec. #: _____ Age: _____
Sex: M F Marital Status: S M D W
Occupation: _____
Employer's Name: _____
Work Address: _____
City/State/Zip Code: _____
Who may we thank for referring you / which event did you attend? _____

Insurance Information

Insurance Company: _____
Group #: _____
Subscriber's ID: _____
Phone: ( ) _____
Billing Address: _____
City/State/Zip Code: _____
Insured's Name _____
Insured's Soc. Sec. # _____
Relationship to Patient: _____
Insured's Date of Birth: _____
Insured's Employer: _____
Address _____
Phone number: _____

Emergency Contact Information

Name _____
Relationship: _____
Home Phone: ( ) _____
Work Phone: ( ) _____

Family Information

Spouse's Name: _____
Child's Name: _____ M F DOB _____
Child's Name: _____ M F DOB _____
Child's Name: _____ M F DOB _____

Authorization and Release *Please read and initial each line below and sign at the bottom.*

_____I hereby authorize **Brinson Family Chiropractic** to release information requested by my insurance carrier and/or Workers' Compensations carrier. Additionally, I authorize **Brinson Family Chiropractic** to release information to any hospital or physician I may be referred to by this health care provider.

_____I hereby authorize assignment and payment directly to **Brinson Family Chiropractic** of any major medical benefits and/or Medicare due me. I understand that insurance may not and that Medicare does not pay one hundred percent (100%) of the medical charges. I hereby acknowledge and agree to pay any and all charges that exceed or that are not covered by insurance and/or Medicare, including any deductible. I also acknowledge that I am responsible for reasonable interest, collection, fees, attorney fees of the greater of a) forty percent (40%) or b)$300.00 of the outstanding balance and/or court costs incurred in connection with any attempt to collect amounts I may owe.

_____Payment is due at the time services are provided. Every effort is made to bill most insurances. Your Cooperation is essential – please provide correct and current copies of any and all insurance cards. If there has been a change in you insurance, address, telephone number, and/or employment since your last visit, please notify the receptionist prior to being seen by the health care provider. If special arrangements are necessary, please speak with the office manager prior to being seen.

_____We want to thank you for choosing us as your chiropractic provider. In order to provide you and our other patients with the best care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24-hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients. Our office does reserve the right to charge for a cancellation with less than a 24-hour notice and broken appointments. Thank you for your consideration of our policies.

Patient/Guardian Signature: _____ Date: _____

Quadruple Visual Analogue Scale

Name: _____ Date: _____

Examiner _____ OFFICE: Linton

Please Read Carefully

Note: If you have more than one complaint, please answer each question for each individual complain and indicate the score for each complaint. Please indicate your pain level right now, average pain and pain at it best and worst.

Example:

No Pain Worst Possible Pain

0 1 (2) 3 4 (5) 6 7 (8) 9 10

Headache Neck Low Back Pain

1) What is your pain RIGHT NOW?

No Pain Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

2) What is your TYPICAL or AVERAGE pain?

No Pain Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

3) What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

4) What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

Other Comments: _____

Please list any information in the following since your last visit; include if the issue is ongoing or has been resolved.

ALLERGIES: _____

HOSPITILIZATIONS: _____

SURGERIES / FRACTURES / FALLS: _____

MOTOR VEHICLE ACCIDENTS: _____

MEDICATIONS _____

BRINSON
FAMILY CHIROPRACTIC

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BRINSON

FAMILY CHIROPRACTIC

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understand and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operation and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purposed of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient my request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician has the right to refuse to give care.

Informed Consent for Chiropractic Care

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may renter the patient susceptible to injury. The doctor, of course will not give any treatments or healthcare if he is aware that such care may be contra-indicated. Again it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your healthcare regime.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. I also understand that if I am accepted as a patient by a physician at Brinson Family Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature: _____ Date: _____

REVIEW OF SYSTEMS

Please underline all of the following conditions you have had previously. Please circle all of the following conditions you have now.

GENERAL
General Fatigue
Weakness
Fever
Chills
Weight Change
Night Sweats
Anemia
Bleeding Tendency
Diabetes
Cancer
Thyroid Problems
Allergies
Frequent Illness
Autoimmune Disease

SKIN
Skin Rash
Redness of Skin
Skin Itching
Skin Dryness
Eczema
Hair Changes
Nail Changes
Bruise Easily

EENT
Hearing Trouble
Ringing in Ears
Pain in Ears
Ear Discharge
Vision Trouble
Pain in Eyes
Eye Discharge
Glaucoma
Cataracts
Use glasses/contacts
Nose/Sinus pain
Excessive Drainage
Nose bleeds (chronic)
Nasal Infections
Absence of Smell
Mouth Sores
Bleeding Gums
Enlarged Glands
Absence of Taste
Tonsillitis
Difficulty Swallowing

HEART/CHEST
Chest pain
Cough
Wheezing
Difficult Breathing
Swollen Limbs
Blue Skin
Varicose Veins
Rapid Heart Beat
Heart Palpitations
Heart Murmurs
High Blood Pressure
Tuberculosis
Asthma
Bronchitis
Heart Attack
Other Heart Disorder
Pneumonia

URINARY
Painful urination
Frequent urination
Urgency
Incontinence
Blood in Urine
Kidney Stones
Bed-wetting
Urine odor

GI SYSTEM
Decreased Appetite
Increased Appetite
Abdominal Pain
Hemorrhoids
Excess Gas
Diarrhea (excess)
Constipation (excess)
Heartburn
Irritable Bowel
Vomiting
Excessive Thirst
Rectal Bleeding
Hepatitis
Liver Disease
Gallbladder Disease
Black tarry stools

MALES
Prostate problems
Hernias
Impotence
Pain

FEMALES
Menstrual Pain
Irregular Periods
Itching
Discharge
Hernias
Hot Flashes
Hormone Replace

MALE/FEMALE
Breast Lumps
Redness of breasts
Breast Pain

NEUROLOGIC
Dizziness
Headaches
Fainting
Head Injury
Convulsions
Nervousness
Stroke
Paralysis
Tremors
Memory Loss
Disorientation
Anxiety
Depression
Phobias
Mood Swings

MUSCLE/BONE
Poor Posture
Spine Injury
Scoliosis
Arthritis
Polio
Gout
Fibromyalgia
Muscle Cramps
Joint Pain
Joint Stiffness

Patient Information Update

Primary Care Physician Name:_____

Clinic Phone Number (with area code): ( )_____

Clinic Address:_____

_____

Patient Signature:_____Date:_____

Patient Name (Printed):_____