Eastlake Chiropractic Center

PATIENT REGISTRATION

Full Name: Mr./ Mrs./ Ms. --

Name You Prefer to be Called ("Nick Name"): --

Mailing Address: ---

City:-- State:-------------------- Zip Code:------------------------------

Soc. Sec. No.: -- E-mail Address:---

Home Telephone: ------------------------------------- Cell Phone: ---

Work Telephone: ------------------------------------ Occupation :--

Employer: -- Address: --

City: --------------------------------------- State: ------------------- Zip Code: ----------------------------

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Birthday: -------------------------------- Age: -------------------- Sex: M / F

Spouse/Partner's Name :---

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Insurance Company: --- Telephone: ---------------------------

Name of Insured: --

What is your Relationship to the Insured? Self / Spouse / Dependent / Other: ----------------------------------

ID No. or Social Secuity No.:----------------------------- Group or Claim No. :---------------------------

If Accident Related, Adjuster's Name: ------------------------------------- Telephone: --------------------------

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Whom may we thank for referring you to our office? --

Name of Medical Doctor: --- Telephone: ---------------------------

In case of emergency, please give the name of a friend / relative to contact (not living at same address)

Name: ------------------------------ Home #:-------------------------- Work #: ------------------------------

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I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that Eastlake Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Eastlake Chiropractic Center will be credited to my account receipt. However, I clearly understand and agree that all services rendered me are charged to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable. I hereby agree that I will be assessed one percent (1%) charge per month on any fee not kept current.

Signature: -- Date: ------------------------------

Patient Health Questionnaire

Patient Name ______________________ **Date** __________

When did your symptoms start? ______________ **Describe your symptoms and how they began:**

____

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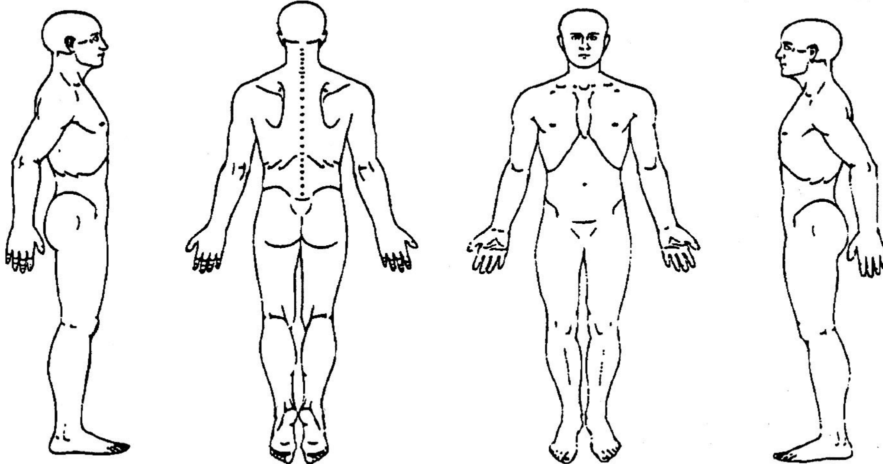
Indicate on the pictures below where you have pain or other symptoms



How often do you experience your symptoms?

- ○ 1-Constantly (76-100% of day)
- ○ 2-Frequently (51-75% of day)
- ○ 3-Occasionally (26-50% of day)
- ○ 4-Intermittently (0-25% of day)

What describes the nature of your symptoms?

- ○ Sharp ○ Shooting
- ○ Dull ache ○ Burning
- ○ Numb ○ Tingling

How are your symptoms changing?

- ○ 1-Getting Better
- ○ 2-Not Changing
- ○ 3-Getting Worse

What is the intensity of your symptoms at their:

	None									Unbearable
worst	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⓪
best	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⓪

Who have you seen for this episode of your symptoms? ○ No one ○ Medical Doctor ○ Other ○ Other Chiropractor ○ Physical Therapist

When and what treatment? ______________________

Have you had the same or similar symptoms in the past? ○ Yes ○ No

If you have received treatment in the past for the same or similar symptoms, who did you see? ○ This office ○ Medical Doctor ○ Other ○ Other Chiropractor ○ Physical Therapist

What tests have you had for your symptoms? ○ Xrays ○ CT Scan ○ MRI Scan ○ Other

What is your occupation?

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- ○ 1-Professional/Executive
- ○ 2-White Collar/Secretarial
- ○ 3-Tradesperson
- ○ 4-Laborer
- ○ 5-Homemaker
- ○ 6-FT Student
- ○ 7-Retired
- ○ 8-Other

If you are not retired, a homemaker or a student, what is your current work status?

- ○ 1-Full-time
- ○ 2-Part-time
- ○ 3-Self-employed
- ○ 4-Unemployed
- ○ 5-Employed, off work due to restrictions
- ○ 6-Other

As a result of your symptoms are you restricted in your ability to perform work and/or daily activities? ○ Yes ○ No

Describe your restrictions ______________________

What type of regular exercise do you perform? ○ 1-None ○ 2-Light ○ 3-Moderate ○ 4-Strenuous

What is your height and weight? Height [ ] [ ] [ ] (Feet, Inches) Weight [ ] [ ] [ ] lbs.

Patient Signature ______________________ **Date** __________

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name ______________________________
PRINTED

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Signature

____
Date

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Eastlake Chiropractic Center, PS

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

(“Consent Form”)

For the purposes of this Consent Form, “Office” shall refer to: Eastlake Chiropractic Center, PS.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office’s privacy notice entitled, “Our Privacy Practices.” I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office’s privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): ____

Signature: ____ Date: ___/___/___