

# CHIROPRACTIC REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date \_\_\_\_\_  
SS/HIC/Patient ID # \_\_\_\_\_  
Patient Name \_\_\_\_\_  
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 \_\_\_\_\_  
Birthdate \_\_\_\_\_  
SS# \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## 2 INSURANCE INFORMATION

Who is responsible for this account? \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_  
Is patient covered by additional insurance?  Yes  No  
Subscriber's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. 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

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## 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 (\_\_\_\_\_) \_\_\_\_\_

## 4 ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?

Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_

## 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) \_\_\_\_\_

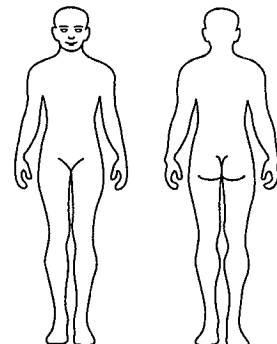
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

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 \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		

## EXERCISE

- None
- Moderate
- Daily
- Heavy

## WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

## HABITS

- Smoking \_\_\_\_\_ Packs/Day \_\_\_\_\_
- Alcohol \_\_\_\_\_ Drinks/Week \_\_\_\_\_
- Coffee/Caffeine Drinks \_\_\_\_\_ Cups/Day \_\_\_\_\_
- High Stress Level \_\_\_\_\_ Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

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

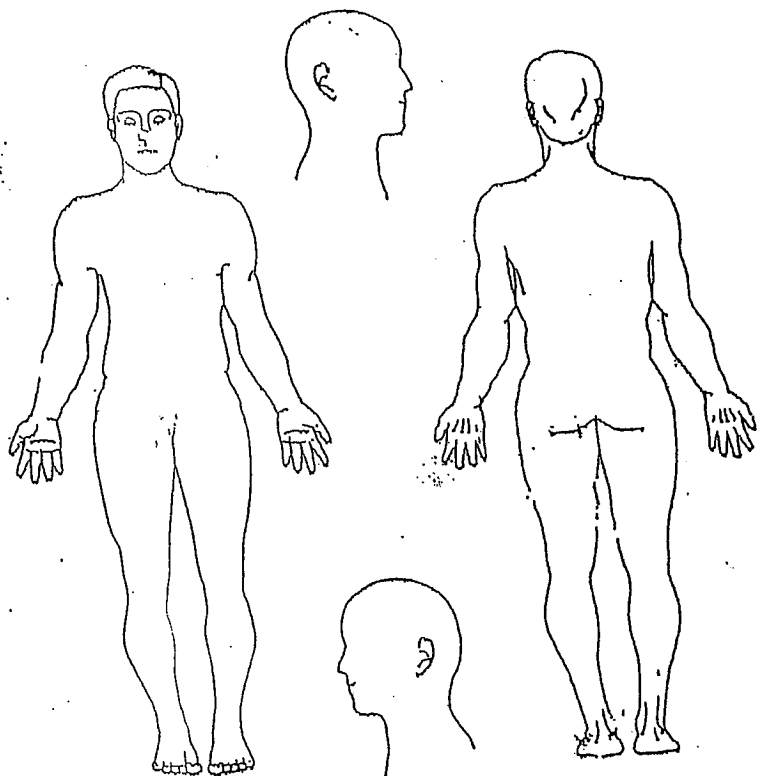
# 7 MEDICATIONS ALLERGIES VITAMINS/HERBS/MINERALS

_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW:



NO PAIN  WORST PAIN IMAGINABLE

HOW BAD IS YOUR PAIN? PLACE AN "X" ON THE ABOVE LINE WHERE YOU FEEL YOUR PAIN IS ON THE SCALE

SIGNATURE: \_\_\_\_\_

**PRIVACY NOTICE ACKNOWLEDGEMENT**

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of  
*Notice of Privacy Practices for Protected Health Information.*

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Authorized Provider Rep.

\_\_\_\_\_  
Personal Representative Printed

\_\_\_\_\_  
Personal Rep. Signature

\_\_\_\_\_  
Description of Personal representatives authority to act for the patient.



# ONION RIVER CHIROPRACTIC

440 MAIN STREET • WINOOSKI, VERMONT 05404 • (802) 655-0354

KELLY A. RYBICKI, D.C.

## ONION RIVER CHIROPRACTIC OFFICE POLICY

- \* PAYMENT FOR INITIAL EXAMINATION IS DUE AT TIME OF TREATMENT UNLESS OTHER ARRANGEMENTS ARE MADE.
- \* ONION RIVER CHIROPRACTIC WILL DIRECT BILL SOME INSURANCE CARRIERS, PLEASE ASK IF YOURS APPLIES.
- \* PAYMENT OF INSURANCE DEDUCTIBLES AND/OR CO PAYMENTS ARE DUE AT TIME OF TREATMENT UNLESS OTHER ARRANGEMENTS ARE MADE.
- \* IN ORDER FOR CHIROPRACTIC TREATMENT TO BE EFFECTIVE A FREQUENCY OF VISITS HAS BEEN DETERMINED FOR EACH PATIENT. PATIENTS ARE EXPECTED TO MAINTAIN THEIR PERSONAL TREATMENT PLAN.
- \* IN CONSIDERATION OF OTHER PATIENTS, ALL PATIENTS ARE EXPECTED TO ARRIVE AT THIS OFFICE AT THEIR PRE-ARRANGED APPOINTMENT TIME. LATE PATIENTS OR WALK INS WILL BE ATTENDED TO AS TIME PERMITS.
- \* 24 HOUR NOTICE MUST BE GIVEN TO CANCEL AN APPOINTMENT. IF NO NOTICE IS RECEIVED A \$20.00 CHARGE WILL BE ASSESSED.

I have read and understand the above notice.

Signature: \_\_\_\_\_

## **ONION RIVER CHIROPRACTIC: INFORMED CONSENT**

**As with all health care professions, Chiropractic is associated with very rare potential risks in the delivery of treatment. While Chiropractic is extremely safe, it is our policy that all patients read and understand fully those possible risks involved with the chiropractic treatment prior to initiating treatment. Please understand that we are highly trained in patient examination and evaluation, allowing us to avoid many of the risks herein.**

**Stroke is the most serious known complication of Chiropractic treatment. It occurs in very rare circumstances after cervical manipulation and is due to an injury to the vertebral artery. Cervical treatment posts a very small risk. The most recent studies indicate that the incidence of stroke is approximately one in every three million cervical adjustment. Practitioners can lower this occurrence even further with proper orthopedic testing and history taking during their examination. Soreness may occur as a side effect after the adjustment and can last for 24-48 hours. This is a normal and accepted response to chiropractic care. If you do feel any abnormal amount of pain or if you are uncomfortable for a prolonged period of time following treatment, please inform us. Soft tissue injury may result from chiropractic care. On occasion discs, joints, ligaments and tendons can become irritated from an adjustment. Rib injury or fracture is a rare side effect of thoracic spine manipulation. Treatment is provided carefully to avoid such circumstances. Physical therapy modalities may cause rare minor burns to the skin and should be reported to the doctor or staff member if they occur. Other rare side effects may occur as a result of Chiropractic care and should be immediately reported to the doctors or staff of Onion River Chiropractic.**

**While we make it a goal to provide the best possible treatment for every one of our patients, it is important that patients understand that we cannot promise a cure for every symptom, condition or disease as a result of treatment in our office. Every attempt will be made to treat your condition to the best of our abilities and if we do not achieve the results we hope for, we will refer you to another provider who we feel can better assist you with your condition. If you have any questions or concerns with the above mentioned material or at any point during your course of care please feel free to ask questions. When you have full understanding of the above mentioned material and consent to receiving chiropractic care in our office, please print your name, sign and date below.**

**PRINT NAME:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

As part of your treatment here, soft tissue massage may be recommended to treat your condition however, due to issues with some insurance companies this may not be a billable service.

In instances when the massage is not billable, there will be a \$5.00 charge in addition to your copay. If you do not wish to have this service performed please let us know before treatment.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_