

## Registration Information

Patient's Name: \_\_\_\_\_

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

Address: \_\_\_\_\_

Male                       Female

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

e-mail: \_\_\_\_\_

### PATIENT INFORMATION:

Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City : \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Business Phone: \_\_\_\_\_

### SPOUSE / PARENT INFORMATION

(If using their insurance)

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SS#: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

### RESPONSIBLE PARTY INSURANCE INFORMATION:

Primary insurance through:

Patient     Spouse     Parent

Insurance Company: \_\_\_\_\_

Secondary insurance through:

Patient     Spouse     Parent

Insurance Company: \_\_\_\_\_

Who is your primary Doctor? \_\_\_\_\_

Name of Attorney: \_\_\_\_\_

Referred by: \_\_\_\_\_

Address: \_\_\_\_\_

Is this problem work related?                       Yes  No

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Is this problem related to Auto Accident?  Yes  No

Phone # \_\_\_\_\_

### Financial Agreement and Authorization for Treatment:

I authorize treatment of the person named above and agree to pay all fees and co-payments for services not covered by a medical plan. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to the provider.

The above information is correct to the best of my knowledge.

There is a \$20 cancellation fee, if this office is not notified 24 hours prior to the appointment. Unpaid balances after 60 days from the date billed will generate late charge of \$5 per month until paid. In the event of litigation regarding this agreement, reasonable attorney fees are to be recovered by the prevailing party.

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

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

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE**

I hereby acknowledge I have received a current copy of Logan Osland Chiropractic "NOTICE OF PRIVACY PRACTICES," from the office staff.

I am aware Logan Osland Chiropractic has included a provision that reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

**Requests:** *(Please check your requests, if any)*

I wish to file a "Request for Restriction" of my Protected Health Information.

I wish to object to the following in the "Notice of Privacy Practices:"

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**I understand this office is not required to honor any changes/objections to the "Notice of Privacy Practices."**

Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Print Name

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**INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENT AND CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-ray, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at that time, based upon the facts then known, and is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**To be completed by patient:**

**To be completed by patient's Representative/Guardian:**

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Print Name of Parent/ Guardian

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Date

## Medical Information Review

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

**Do you now have or have you ever had any of the following?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Kidney Problem     | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Seizures           | <input type="checkbox"/> Heart Attack        |
| <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Hernia              |
| <input type="checkbox"/> Headaches      | <input type="checkbox"/> Nervous Disorders  |  |
| <input type="checkbox"/> Cancer         | <input type="checkbox"/> Previous Surgeries |  |

If yes to any of the above, please explain and give appropriate dates.

**Do you now have any of the following symptoms?**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Vertigo             | <input type="checkbox"/> Ringing in Ears      |
| <input type="checkbox"/> Change in Appetite   | <input type="checkbox"/> Weight Changes      | <input type="checkbox"/> Energy Level Changes |
| <input type="checkbox"/> Fever                | <input type="checkbox"/> Night Sweats        | <input type="checkbox"/> Swollen Glands       |
| <input type="checkbox"/> Cough                | <input type="checkbox"/> Nosebleeds          | <input type="checkbox"/> Vision Changes       |
| <input type="checkbox"/> Pain with Swallowing | <input type="checkbox"/> Digestion Problems  | <input type="checkbox"/> Chest Pains          |
| <input type="checkbox"/> Bowel Changes        | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Bladder Changes      |
| <input type="checkbox"/> Palpitations         |  |   |

If yes to any of the above, please explain and give appropriate dates.

**Have you or any of your family been treated for the following?**

- |   |                              |                             |            |
|---|------------------------------|-----------------------------|------------|
| Tuberculosis  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Cancer  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Arthritis   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Kidney Disease  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Asthma/Difficulty breathing   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Heart Problems<br>(e.g. Heart Murmur, History of Heart Attack, Irregular Heartbeat) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Epilepsy  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Stomach trouble/Ulcers  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Dizziness   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Nerve disorders   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Muscular disorders  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Hypertension  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Bowel/Bladder disorders   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Excessive Bleeding  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Diabetes  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Liver problems  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Rheumatic Fever   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Migraine Headaches  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Thyroid/Hormone problem   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Stroke  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |
| Seizures  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who? _____ |

Do you exercise regularly?  yes  no      Have you ever smoked cigarettes?  yes  no

Do you drink caffeine beverages?  yes  no      Do you drink alcoholic beverages?  yes  no

Have you ever used illicit drugs?  yes  no

If yes to any of the above, please explain and give appropriate dates.

If you are **female** - Are your menstrual cycles normal:  yes  no  
 Are you pregnant:  yes  no

# Medical Information Review

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

**Operations/Surgeries**

**Dates**

_____	_____
_____	_____
_____	_____

**Have you ever had X-rays, MRI's or a C-T Scan performed?  
Name of the facility and what was done?**

**Dates**

_____	_____
_____	_____
_____	_____

**Do you have any conditions or diseases? If yes, please list and explain.**

_____	_____
_____	_____
_____	_____

**Do you have any allergies? If yes, Please list and explain.**

_____
_____
_____

**Prior chiropractic treatment? If yes, please list last visit.**

_____
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**Current Medications:**

**Conditions for which they were prescribed:**

_____	_____
_____	_____
_____	_____

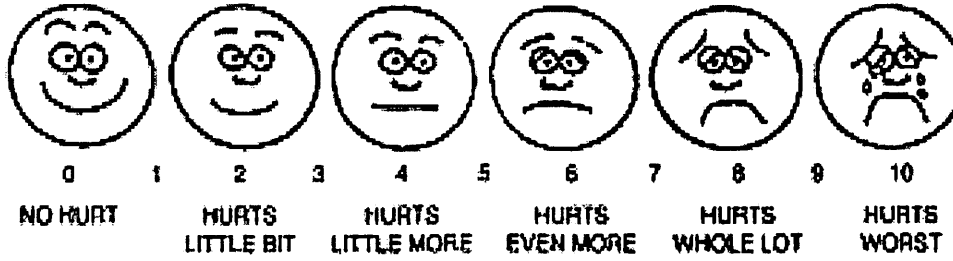
**Height: \_\_\_\_\_ Weight: \_\_\_\_\_**

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

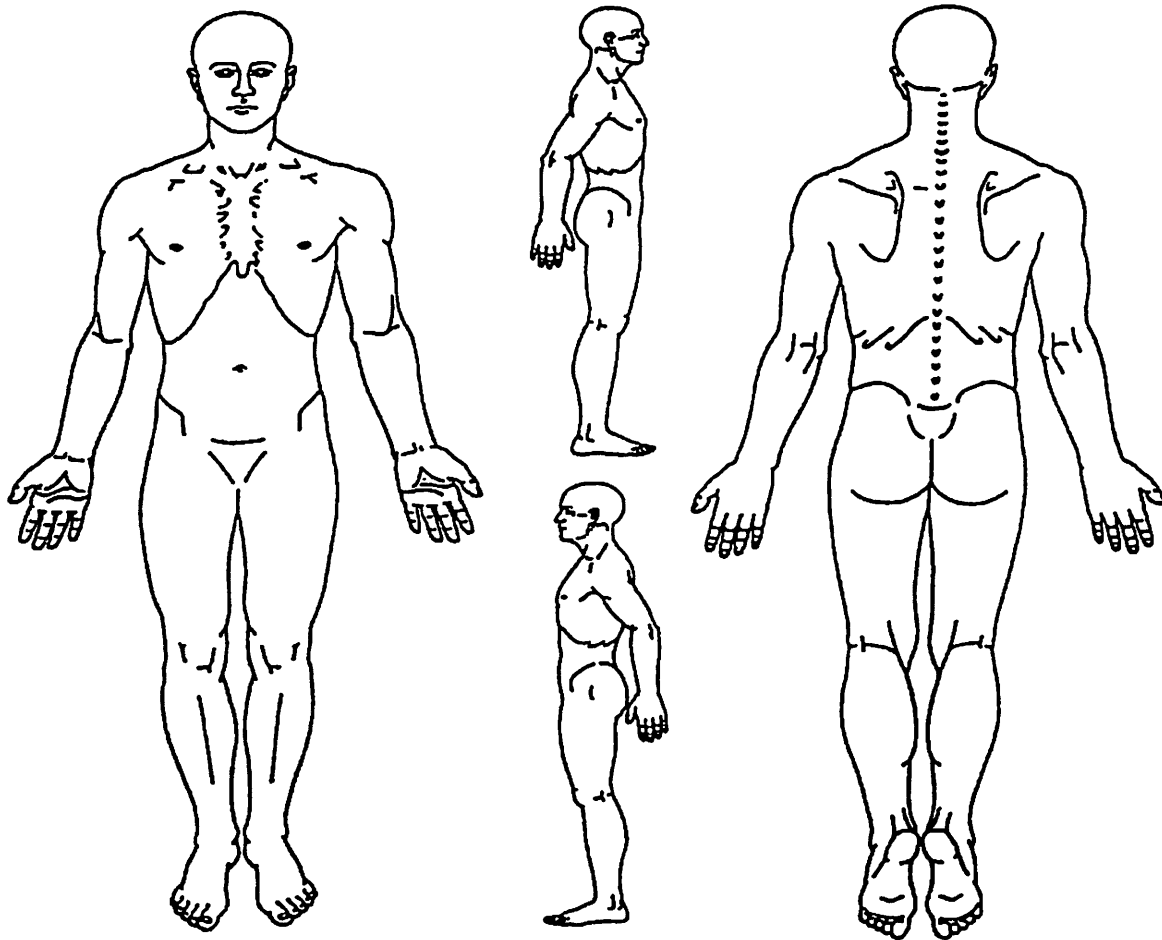
Chief Complaint: \_\_\_\_\_

Circle the number that best describes the level of your pain.

### Wong Baker Face Scale



Mark specific area of pain.



Ht \_\_\_\_\_

Wt \_\_\_\_\_

BP \_\_\_\_\_

P \_\_\_\_\_

R/L