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? _____

Referred by: _____

Is this problem work related? ☐ Yes ☐ No

Is this problem related to Auto Accident? ☐ Yes ☐ No

Name of Attorney: _____

Address: _____

City: _____ State: _____ Zip: _____

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:"

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

Signature _____ Date_____

_____

Print Name

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:

_____

Print Patient's Name

_____ _____

Signature of Patient Date

_____ _____

Signature of Doctor Date

To be completed by patient's Representative/Guardian:

_____

Print Name of Parent/ Guardian

_____ _____

Signature of Parent / Guardian Date

Medical Information Review

Name: _____ Date: _____

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

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Metal Implants
- ☐ Headaches
- ☐ Cancer
- ☐ Kidney Problem
- ☐ Seizures
- ☐ Pacemaker
- ☐ Nervous Disorders
- ☐ Previous Surgeries
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Hernia

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

Do you now have any of the following symptoms?

- ☐ Dizziness
- ☐ Change in Appetite
- ☐ Fever
- ☐ Cough
- ☐ Pain with Swallowing
- ☐ Bowel Changes
- ☐ Palpitations
- ☐ Vertigo
- ☐ Weight Changes
- ☐ Night Sweats
- ☐ Nosebleeds
- ☐ Digestion Problems
- ☐ Shortness of Breath
- ☐ Ringing in Ears
- ☐ Energy Level Changes
- ☐ Swollen Glands
- ☐ Vision Changes
- ☐ Chest Pains
- ☐ Bladder Changes

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

_____

Current Medications: **Conditions for which they were prescribed:**

_____ _____

_____ _____

_____ _____

Height: _____ **Weight:** _____

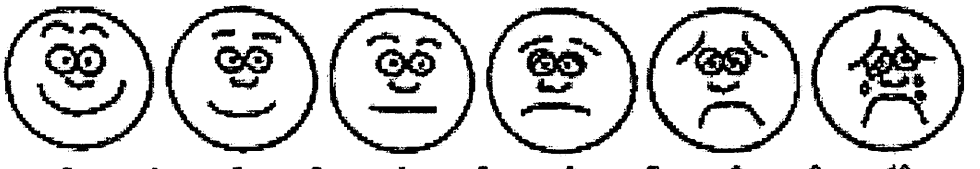
Name/*Nombre:* _____ Date/*Fecha:*_____

Chief Complaint/Cuál es su motivo de consulta: _____

_____

Circle the number that best describes the level of your pain/ Circule el número que mejor describe el nivel de su dolor

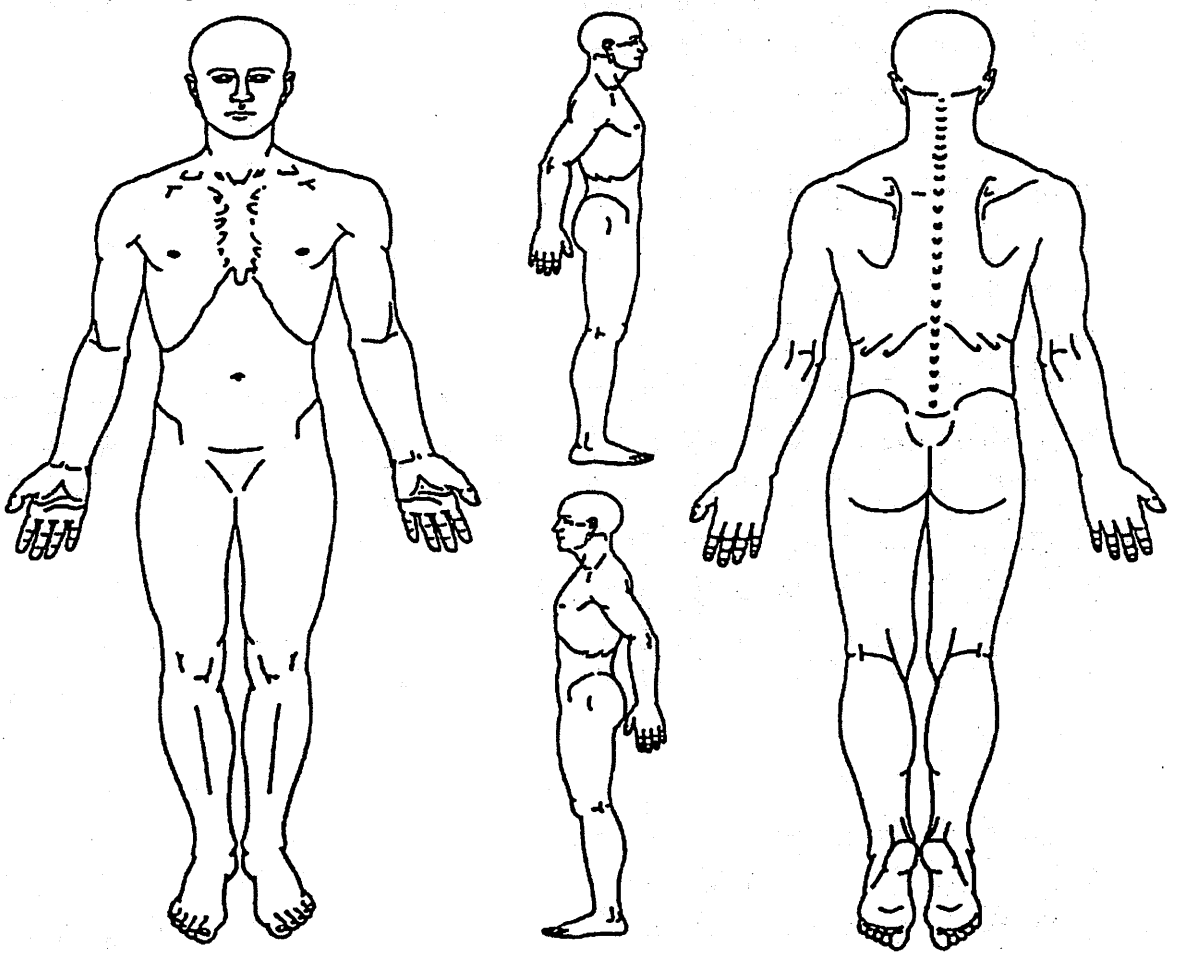
Wong Baker Face Scale



0	1	2	3	4	5	6	7	8	9	10
NO HURT		HURTS LITTLE BIT		HURTS LITTLE MORE		HURTS EVEN MORE		HURTS WHOLE LOT		HURTS WORST

NO DUELE	DUELE UN POCO	DUELE UN POCO MAS	DUELE MUCHO	DUELE MUCHO MAS	DUELE MAXIMO

Mark your specific area(s) of pain/marcar su área o áreas de dolor específico



Ht_____ Wt_____ BP_____ P_____ R/L