CHIROPRACTIC REGISTRATION & HISTORY

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

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

PHONE NUMBERS

Home Phone (_____) _____ Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

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) _____

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) _____

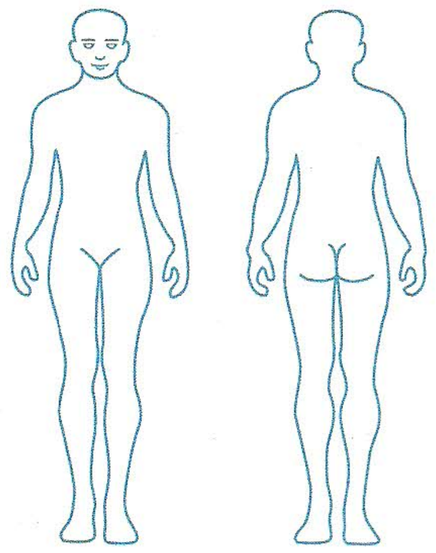
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

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



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

MEDICATIONS

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

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

Dr. Karen N. Lewis, Family Chiropractor

PATIENT CONSENT FOR USE AND /OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT,
PAYMENT AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1) The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and /or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2) The Practice reserves the right to change its privacy Practices that are described in its Privacy Notice, in accordance with applicable law.

3) I understand that , and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me: and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4) The Practice may use and / or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5) I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6) I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7) I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8) I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (PRINTED)	Signature of Individual
Signature of Legal Representative (Guardian, Parent if a minor)	Relationship
Date Signed	Witness

Dr. Karen N. Lewis / Family Chiropractor
811 West Chester Pike, West Chester, PA 19382 (610) 696-0460

Terms of Acceptance

When a person seeks chiropractic health care, and when a chiropractor accepts a person for such care, it is essential that they both be working toward the same goal.

As a chiropractor I am interested in your total health picture. It is of paramount importance that all communication between us be kept truthful and confidential. There must also be complete cooperation between us in working towards the common goal of improving your health awareness and status.

Improving one's state of health is an ongoing process that takes a great deal of time and energy for both the doctor and the patient. The patient must realize a majority of the responsibility of his/her own health. Therefore, the patient must understand the enormous impact of his/her particular lifestyle and how it directly relates to his/her state of health and time of healing. The patient must understand that the healing process takes place within his/her body. The chiropractor is only a tool to aid the healing process. Therefore, a chiropractor does not treat or heal any disease conditions. The diagnosis and treatment of disease and the offering of advice about disease constitutes the practice of medicine, not chiropractic.

The primary goal and purpose of chiropractor is to restore and maintain the mechanical integrity of the spinal column, spinal cord, and its nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine. Minor misalignments of the bones of the spine which interfere with the function of these nerve pathways are called vertebral subluxations. Subluxations are directly and indirectly a result of various stress factors confronting us every day. Stress factors such as emotional, mental, chemical, and physical stress can be overwhelming and cause vertebral Subluxations. The primary goal of chiropractic care is to correct vertebral Subluxations for the purpose of restoring normal nerve function so that every part of the body may have proper nerve supply at all times.

With proper nerve supply, the body always functions more efficiently than it could with a damaged nerve supply. While it is true that correction of Subluxations allow the body to better express its innate potential and to more effectively carry out all its functions, including healing, chiropractic does not offer a way of diagnosing or treating specific diseases. However, disease conditions often improve under chiropractic care. Chiropractic does offer a way of improving one's overall health.

I, _____ have read the above, understand it fully, and undertake chiropractic care on this basis.

Name: _____

Date: _____

Dr. Karen Lewis, Family Chiropractor

PRIVACY CONFIDENTIALITY STATEMENT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

DISCLOSURE OF INFORMATION

We may disclose information to other healthcare professionals and/or your insurance carrier for treatment. payment or healthcare operations. Additional disclosures may be necessary to comply with Workers' Compensation and Public Health Laws as well as Judicial proceedings. We may contact a family member or other authorized person in the event of an emergency. Be assured that we will not disclose any information without your expressed written consent unless compelled to do so by legal authority. Further you will be contacted by phone or mail in the event a request for information is made.

FACILITY SET UP

While our examination and treatment room is private, this office utilities an open reception area that is shared with other healthcare professionals. The doctor and staff will maintain policies to ensure privacy, but there may be some inadvertent disclosure to others in the facility at the same time. If there is private information that you need discussed please request to have such discussions in a private room.

YOUR RIGHTS

1) Send us a written request to see or procure a copy of the information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as another doctors or hospitals.

2) Request additional restrictions on used and disclosures of your health information. We are not required to agree to these requests and in some instances they may be prohibited by law.

3) Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address.

4) Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment or health care operations, or the law otherwise restricts the accounting.

5) You have the right to inspect and have a copy of your health information. There is no cost for the first copy; any copy thereafter will be $25.00.

6) You have the right to amend your information. Please note that we have the right to disagree with your amendments. If there is disagreement you will be provided with information about our denial of your amendment and how you may appeal the denial of amendment.

7) You have the right to a copy of the notice upon request.

COMPLAINTS

about your privacy rights or how your privacy is handled at this office can be directed to K.L. Privacy by calling this office or directing a letter to her attention. If you are not satisfied with how this office handles your complaint you may submit a formal complaint to: DHHS (Office of Civil Rights), 200 Independence Ave, S.W., Room 509F HHH Building, Washington, DC 20201

I have read this Privacy Notice and understand my rights contained in this notice. By signing this form I provide authorization and consent to use and disclose my protected health information as noted above.

Name of Patient (PRINTED)	Signature of Patient	DATE