

# Chiropractic Registration and History

## Patient Information

Date \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Patient's SSN \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birth date \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone ( ) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Birthdate \_\_\_\_\_

Spouse's SSN \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

How did you hear about our practice/

Whom may we thank for referring you? \_\_\_\_\_

## Phone Numbers

Home ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

IN CASE OF EMERGENCY, CONTACT:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

## Patient Condition

Reason for visit/Primary complaint(s): \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you are experiencing 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/movements that are painful to perform:  Sitting  Standing  Walking  Bending  Lying Down

## Insurance

Who is responsible for this account? \_\_\_\_\_

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

Insurance Co. \_\_\_\_\_

Member ID # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birth date \_\_\_\_\_ SS# \_\_\_\_\_

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

Secondary Insurance Co. \_\_\_\_\_

Secondary Member ID \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to DR. MURRAY 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 Rep.

\_\_\_\_\_  
Date

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

## Accident Information

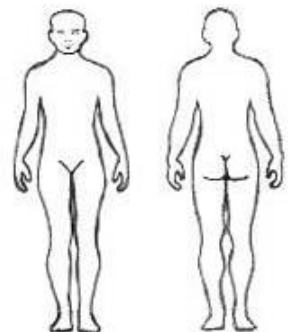
Is condition due to an accident?  Yes, date \_\_\_\_\_  No

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) \_\_\_\_\_



# Health History

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

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 \_\_\_\_\_    \*\*=MRI/CT of what part of the body? \_\_\_\_\_

**Where was scan performed (facility name)?** \_\_\_\_\_

Please 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	Rheumatoid Arthritis	<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	Rheumatic 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	<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	Headaches	<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	Miscarriage	<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	Mononucleosis	<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	Multiple Sclerosis	<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	Mumps	<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	Osteoporosis	<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	Pacemaker	<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	Parkinson's Disease	<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	Pinched Nerve	<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	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<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	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<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	Prostate Problem	<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	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
				Psychiatric Care	<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	_____	_____

List any medications/vitamins/supplements you are taking as well as any allergies:

Pharmacy Name:  
Pharmacy Phone:



## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

\_\_\_\_\_  
{Print Patient's Name}

I have received or reviewed a copy of this office's  
Notice of Privacy Practices  
available at the front desk or online at  
[www.BetterBacksChiropractic.com](http://www.BetterBacksChiropractic.com)

Signed,

\_\_\_\_\_  
{Signature of Patient / Parent (if minor) / Authorized Representative}

\_\_\_\_\_  
{Date}

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### For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

## **Informed Consent to Chiropractic Treatment**

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;
- b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;
- c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

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

\_\_\_\_\_  
**Patient Signature (or Legal Guardian)**

\_\_\_\_\_  
**Signature of Staff Witness**

**Patient Name:** \_\_\_\_\_  
(please print)

**Witness Name:** \_\_\_\_\_  
(please print)

## **Prior Chiropractic Treatment Information**

Name of Chiropractor: \_\_\_\_\_ Location (city): \_\_\_\_\_

When was your last treatment? \_\_\_\_\_ Have you had x-rays? \_\_\_\_\_



BRIAN M. MURRAY, D.C. & MICHELE L. MURRAY, D.C

HIGH DEDUCTIBLE DOWN-PAYMENT POLICY

The following may or may not apply to you at this time. We do ask that all of our patients sign this acknowledgement.

All co-pays are due at the time of service. Partial deductible payments (if applicable) are also requested.

If the chiropractic benefit under your insurance plan involves a high deductible (>\$750) and our billing manager anticipates a zero-payment from your insurance for your office visit, a partial down-payment is requested. The down-payment will not cover your visit in full, but it will credit to your account. After the claim is processed, your insurance will reduce our fees to the contracted rates and **your payment will be applied to the final charges incurred. You will receive a bill for any balance due.**

Requested at initial visit (examination/treatment): *up to* \$75

Requested for follow-up visits: \$30 per visit.

\*Note: If you are unable to remit the applicable payment you may be asked to reschedule your appointment.

It is your responsibility to be aware of the chiropractic benefits available to you through your insurance. Please ask our office staff if you have any questions or would like a benefit quote.

I ACKNOWLEDGE RECEIPT AND UNDERSTANDING OF THE ABOVE INFORMATION.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Staff witness: \_\_\_\_\_