

CONFIDENTIAL PATIENT REGISTRATION AND HISTORY

| 1 | PATIENT INFORMATION |
|---|----------------------------|
| Date: _____ | |
| Name: _____ <small>First Name Initial Last Name</small> | |
| Address: _____ _____ | |
| Home Phone #: _____ | |
| Work Phone #: _____ | |
| Cell Phone #: _____ | |
| E-mail Address: _____ | |
| Sex: <input type="checkbox"/> M <input type="checkbox"/> F Age: _____ Birth date: _____ | |
| <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | |
| Social Security #: _____ | |
| Occupation: _____ | |
| Employer: _____ | |
| Employer Address: _____ | |
| Employer Phone #: _____ | |
| # Hours / Week Worked: _____ | |
| <i>IN CASE OF AN EMERGENCY, CONTACT</i> | |
| Name: _____ Relation: _____ | |
| Phone #: _____ | |
| Is condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Auto (Complete Section 3 Below) | |
| <input type="checkbox"/> Work / Home / Other (Complete Section 4 on the next page) | |
| PRIMARY PHYSICIAN: _____ | |
| How did you hear about us? _____ | |

| 2 | INSURANCE INFORMATION |
|---|------------------------------|
| Health Insurance (Primary) | |
| Ins Co.: _____ Phone: _____ | |
| Policyholder name: _____ | |
| Relationship to policyholder: _____ | |
| Policyholder Date of Birth: _____ | |
| Policy #: _____ Group #: _____ | |
| Health Insurance (Secondary) | |
| Ins Co.: _____ Phone: _____ | |
| Policyholder name: _____ | |
| Relationship to policyholder: _____ | |
| Policy #: _____ Group #: _____ | |
| Complete the following if injury is related to an auto accident. | |
| Motor Vehicle Insurance (Your PIP Info) | |
| Owner of vehicle in which you were injured: _____ | |
| Ins Co.: _____ Phone: _____ | |
| Policy #: _____ | |
| Claim #: _____ | |
| Have you retained an attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Name: _____ Phone: _____ | |
| Third Party Information (Other vehicle that struck yours) | |
| Name: _____ Phone: _____ | |
| Ins Co.: _____ Phone: _____ | |
| Policy #: _____ Claim #: _____ | |

| 3 | Auto ACCIDENT INFORMATION (IF APPLICABLE) |
|---|--|
| Date of Injury: _____ Time: _____ State: <input type="checkbox"/> DC <input type="checkbox"/> MD <input type="checkbox"/> VA <input type="checkbox"/> PA <input type="checkbox"/> Other _____ | |
| Describe in DETAIL how your injury occurred: _____ _____ | |
| Were you the: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger Were you sitting in the: <input type="checkbox"/> Front Seat <input type="checkbox"/> Back Seat | |
| Were you struck from: <input type="checkbox"/> Behind <input type="checkbox"/> Front <input type="checkbox"/> Left Side <input type="checkbox"/> Right Side Were you wearing a seatbelt? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Did you know you were going to be hit? <input type="checkbox"/> Yes <input type="checkbox"/> No Did you brace for impact? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Approximate speed your vehicle was traveling _____ mph OR were you stopped? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Approximate speed the other vehicle(s) were traveling _____ mph | |
| Make & Model of your vehicle: _____ Make & Model of other vehicle: _____ | |
| Were police notified? <input type="checkbox"/> Yes <input type="checkbox"/> No Did the police file a report? <input type="checkbox"/> Yes * <input type="checkbox"/> No | |
| * If yes, you must provide a copy of this report to this office within 5 business days of today's date. | |
| What was the approximate damage to vehicle: <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Extensive <input type="checkbox"/> Totaled | |
| Amount of Damage: \$ _____ Was your vehicle towed from the scene? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Patient Name: _____

4

Work (or Other) INJURY INFORMATION (IF APPLICABLE)

Date of Injury: _____ Time: _____ State: DC MD VA PA Other _____

Describe in DETAIL how your injury occurred: _____

5

CURRENT COMPLAINTS

What are your present complaints? (Location of pain, etc.) _____

Use an "X" on the drawing to mark where you are experiencing pain (or other symptoms).

When did these symptoms first appear? _____

Do your symptoms interfere with: Sleep Daily routine Work Recreation

Are you working less hours / days as a result of your injuries? Yes No

If yes, please explain _____

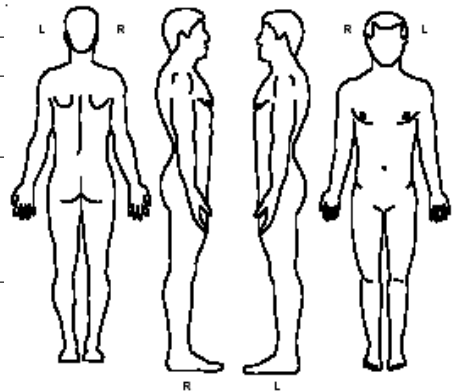
Activities or movements that are painful to perform:

Sitting Standing Walking Bending Lying Down

How would you rate your symptoms: Mild Moderate Severe

How would you rate your current symptoms (pain): 0 1 2 3 4 5 6 7 8 9 10
No Symptoms Worst Possible

Since the accident (if applicable), are your symptoms: Improving Unchanged Worsening



6

HOSPITALIZATION / EXAMINATION HISTORY

Have you been to the hospital for this condition? Yes No If yes, name of hospital? _____

When did you go? _____ How did you get there? Ambulance Self Others

Were x-rays taken? Yes No If yes, what area(s)? _____

Were you prescribed any medication? Yes No If yes, what medications? _____

Have you seen any other doctor or received any other treatment for your current condition? Yes No

If yes, explain _____

Doctor's name and address: _____

Phone #: _____ Date(s) seen: _____ Diagnosis: _____

DIAGNOSTIC TESTING YOU MAY HAVE RECEIVED: (place "X" in boxes that apply)

| Test | Region / Body Part(s) | Date(s) | Test | Region / Body Part(s) | Date(s) |
|--------------------------------------|-----------------------|---------|------------------------------------|-----------------------|---------|
| <input type="checkbox"/> Examination | _____ | _____ | <input type="checkbox"/> EMG / NCV | _____ | _____ |
| <input type="checkbox"/> MRI / CT | _____ | _____ | <input type="checkbox"/> _____ | _____ | _____ |

Patient Name: _____

7

HEALTH HISTORY / INJURIES / TREATMENTS

INJURIES YOU MAY HAVE HAD IN THE PAST

Description

Date (s)

Auto Accident (s) _____
Work Injuries _____
Broken Bones _____
Other _____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING OR SUFFERING FROM: (place "✓" in boxes that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Muscle disorder | <input type="checkbox"/> Lungs, Asthma | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Nervous System Disorder | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Bone Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Seizures/Convulsions` | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> HIV | <input type="checkbox"/> A Congenital Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hernias |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ears, eyes, nose, throat |
| <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Kidney, Bladder (GU) | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Stomach, Intestines (GI) | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Heart Disease |

SURGERIES YOU MAY HAVE HAD FOR THIS CONDITION:

Date (s)

Spine Surgeries Discectomy Laminectomy Fusion Other: _____
Other Surgeries _____

NON-SURGICAL TREATMENTS YOU MAY HAVE RECEIVED FOR THIS CONDITION: (place "✓" in boxes that apply)

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Medication (OTC / Prescription) | <input type="checkbox"/> Injections | <input type="checkbox"/> Physical Therapy (Dates: _____) |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Other: _____ | | |
| <input type="checkbox"/> List ALL Meds: _____ | | |

Female patients: Start date of most recent menstrual cycle: _____ Are you currently pregnant? Yes No

8

YOUR DOCTORS

Please List ALL Doctors involved in your healthcare, present and past. (Use back if necessary)

| | <i>Name</i> | <i>Phone</i> |
|--------------------------|-------------|--------------|
| Primary / Family Doctor: | _____ | _____ |
| Orthopedic Doctor: | _____ | _____ |
| Pain Management: | _____ | _____ |
| Neurologist: | _____ | _____ |
| Chiropractor: | _____ | _____ |

9

AUTHORIZATION FOR TREATMENT

I hereby authorize the Doctor to treat my condition as he/she deems appropriate and to furnish any authorized requests for information regarding treatment. It is understood and agreed that the amount paid to the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office. They will be kept on file where they may be seen at any time while the patient is being treated at this office. The patient also agrees that he/she is responsible for all bills incurred at this office. (The Doctor will not be held responsible for any preexisting medically diagnosed conditions, nor for any medical diagnosis). The patient also agrees that statements made in this questionnaire are true and correct.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Patient Name: _____

Advanced Chiropractic of Grove City Consent to Services

PATIENT'S RIGHTS

Pt. Initials _____

Advanced Chiropractic of Grove City (ACGC) respects the unique differences of our patients, and will ensure that health care ethics are maintained for all patients. The following rights will be exercised on our patients' behalf:

1. The patient has the right to considerate and respectful care.
2. The patient has the right to and is encouraged to obtain from the doctor relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
3. The patient has the right to know the identity of the doctor, staff, and all involved in patient care.
4. The patient has the right to make decisions about the plan of care prior to and during the course of treatment, and to refuse a recommended treatment or plan of care to the extent permitted by law, and to be informed of the consequences of this action.
5. The patient has the right to every consideration of privacy.
6. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases where reporting is permitted or required by law.
7. The patient has the right to expect reasonable continuity of care when appropriate and to be informed by the doctor of available and realistic patient care options.

CONSENT TO TREATMENT OF A MINOR CHILD (Under the age of 18)

Pt. Initials _____

I authorize Chiropractic &/or Rehab Therapy care as deemed necessary to my (relationship)_____.

FEMALE PATIENTS (ONLY)

Pt. Initials _____

This is to certify that, to the best of my knowledge, I am NOT pregnant and that ACGC has my permission to take x-rays. Beginning date of last menstrual period _____.

INITIAL EXAM & CONSULT VISIT (FIRST & SECOND Visit)

Pt. Initials _____

This includes x rays and consult visit to receive results. An initial History & Physical will be sent to your Primary Care Doctor, unless otherwise requested.

PAYMENT, INSURANCE, MEDICAL RECORDS, AND USE OF NAME (for treatment; if you take care)

Pt. Initials _____

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum in now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for products or professional services rendered will be immediately due and payable.

CONSENT TO CHIROPRACTIC &/OR PHYSICAL THERAPY SERVICES

Pt. Initials _____

I hereby request and consent to comprehensive examinations (chiropractic &/or physical therapy orthopedic &/or neurological), chiropractic adjustments/treatments (*and other procedures including various modes of physiotherapy modalities*), physical therapy intervention (*including soft tissue mobilization, therapeutic exercises, stretching, posture and ergonomic training, and home exercise program*), nutritional counseling/advice, and diagnostic x-rays by ACGC (*& it's staff*), who now or in the future treat me in this office. I have had an opportunity to discuss with the ACGC Staff the nature and the purpose of the treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine, the practice of chiropractic and in the practice of physical therapy there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications, and wish to rely on the doctor(s) to exercise judgment during the course of any procedure which the doctor(s) feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by ACGC and/or employed staff.

NO SHOW/CANCELLATION/LATE POLICY

Pt. Initials _____

ACGC has the right to charge a fee of \$25.00 for appointments not cancelled within 24 hours of scheduled time or not showing for scheduled appointment and payment will be due on next visit. If patients show up for appointments more than 15 minutes late we may re-schedule or full treatment will not be given.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

PRINTED _____ SIGNED _____ DATE _____