CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____

City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birthdate_____ SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?_____

_____

2 INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

policy#_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

3 PHONE NUMBERS

Home_____ Work_____ Ext____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Home Phone_____ Work Phone_____

4 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)_____

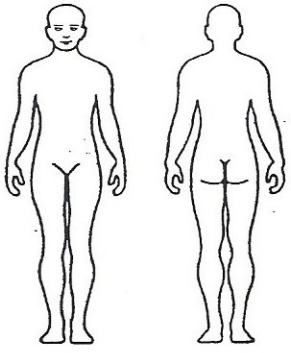
5 PATIENT CONDITION

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

- O V E R -

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

7 MEDICATIONS

_____
_____
Pharmacy Name_____
Pharmacy Phone _____

ALLERGIES

VITAMINS/HERBS/MINERALS

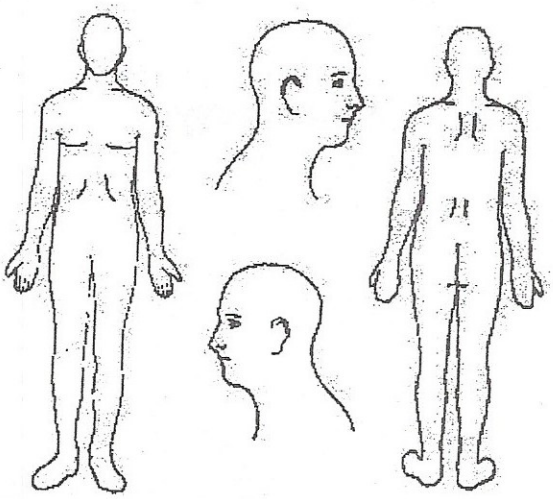
Date of Visit: ___/___/___ Patient: _____ Age: _____

What brought you here today? _____

_____

Place an "X" on the drawing below on areas causing you pain and a letter describing it

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES



PAIN SCALE

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Describe your past health history:

Prior Illness: _____

_____

Past Hospitalizations: _____

_____

Surgeries: _____

_____

Medications: _____

Patient Signature: X _____

(DO NOT WRITE BELOW THIS LINE)

EXAMINATION

Range of Motion

Cervical	Normal		Pain
Flexion	50		
Extension	60		
Left Lat Flex	45		
Right Lat Flex	45		
Left Rotation	80		
Right Rotation	80		
Lumbar	**Normal**		**Pain**
Flexion	60		
Extension	25		
Left Lat Flex	25		
Right Lat Flex	25		
Left Rotation	30		
Right Rotation	30		

Health HX Notes:

_____

_____

_____

_____

_____

_____

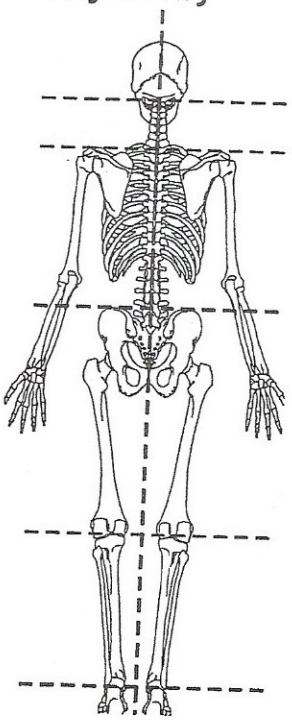
Asymmetry

C0
C1
C2
C3
C4
C5
C6
C7

L1
L2
L3
L4
L5
SAC
L-IL
R-IL

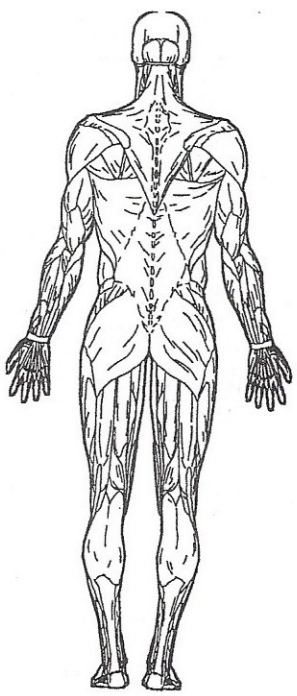
T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12

Using arrows (↑ ↓ → ←) mark the misaligned vertebrae



Using arrows (↑↓), mark postural asymmetry

Tissue



Mark tissue abnormalities
TP, LG, TN, SK, FS

TP=Trigger Points; LG=Ligaments (swollen or tender)
TN=Tendons; SK=Skin; FS=Fascial Restrictions

HISTORY OF PRESENT COMPLAINT

Complaint: _____

Qual & Chara: _____

On, Dur, Intens, Freq, Loc, Rad _____

_____

_____

Better or worse _____

_____

Prior TX, meds, other: _____

_____

EXAMINATION

Reflexes
(Wexler Scale)

Biceps ____
Triceps ____
Brac/rad____
Patella ____
Achilles____

B/P: ___/___ **PULSE:** _____ **RESP:** ____ **HT:** _____ **WT:** ____ **GRIP: (R)** ____ **(L)** ____

Sensory: C5: _____ C6: _____ C7: _____ C8: _____ T1: _____
L3: _____ L4: _____ L5: _____ S1: _____

D= Deficit **N= Normal** **(R) or (L)**

General Orth/Neuro Examination:

Spinous Percus: _____ Valsalva: _____

Dejerine Triad: _____ Rhomberg: _____ **(+) or (-), (R) or (L)**

Notes: _____

Test	(+)	(-)	R	L	Indication
Distraction					nerve root compression
Jackson					nerve root compression
Max Cerv Rot Comp					nerve root compression
Cerv Comp					nerve root compression
Soto Hall					(cerv) (thor) vertebral trauma
Spurlings					nerve root irritation
Shoulder Depress					nerve root compression

	(+)	(-)	R	L	Indication
Libman's					(low) (normal) (high) pain threshold
Burn's Bench					(hysteria) (malingering)
Hoover's					(hysterical paralysis) (malingering)

	(+)	(-)	R	L	Indication
Bechterew					sciatic disk compression
Beevor's					abdominal muscle weakness
Minors Sign					radicular disk pain
Ely					upper lumbar lesion
Fajersztajn					intervertabral disk syndrome
Nachlas					upper lumbar lesion
Gluteal punch					spinal lesion
Goldthwaite					lumbar differentiation
Heel walk					5th lumbar motor deficit
Kemps					intervertebral disk rupture
Lasague					(muscle) (disk) (nerve) irritation
Braggards					lumbar antalgic spasm
Supported Adam's					lumbosacral differentiation

MUSCLE TESTS

Level	Muscle	Muscle Grade	
C5	Deltoids	L:	R:
C6	Biceps	L:	R:
	Wrist extensors	L:	R:
C7	Triceps	L:	R:
	Wrist flexors	L:	R:
	Finger extensors	L:	R:
C8	Finger flexors	L:	R:
T1	Finger abductors	L:	R:
L2 -L3	Hip flexors	L:	R:
L4-L5	Hip extensors	L:	R:
L3-L4	Knee extensors	L:	R:
L5-S1	Knee flexors	L:	R:
L4-L5	Ankle extensors	L:	R:
S1-S2	Ankle flexors	L:	R:

TREATMENT PLAN

Initial TX on: ___/___/___

Level of Care: (include duration and frequency of visits)

_____

_____

_____

Specific Treatment Goals: _____

_____

Specific Objective Eval: _____

_____

_____

DIAGNOSIS: _____

_____

_____

Doctor Signature: _____ **Date:** ___/___/___

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains.
With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events! per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

Gill Chiropractic

By the Sea

Richard M. Gill, D.C.L.L.C.
Chiropractor for Children & Adults

312 Morris Avenue, Spring Lake, NJ 07762
Phone: (732) 974-7755 ◦ Fax: (732) 974-7733

PRIVACY CONSENT FORM/REQUIRED BY FEDERAL HIPAA LAW #101-191
For Use or Disclosure of Private Health Information

- Trust is the foundation of a doctor/patient relationship.
- The information that you provide us is kept in the strictest of confidence.
- While protecting your privacy is extremely important to us, there may be certain situations in which we may have to use or disclose your health care information:
  1. It may be necessary to use or disclose your private health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health information.
  2. It may be necessary to use or disclose your private health information and billing records to another party if they are responsible for the payment of your services.
  3. It may be necessary to use or disclose your private health information within our practice for quality control and operational purposes.

Please Note:
We have a more detailed "Notice of Privacy for Private Health Information" and you have the right to review the detailed notice before you sign this consent form. We have the right to change our privacy practices as described in the detailed notice. If any changes occur in reference to our privacy practices you will be notified by a posting of the change in the office or a notice will be sent to you in the mail. You may request a copy of our privacy notices at any time.

Patient Rights Under HIPAA LAW#101-191

1. You have the right to request that we do not disclose your private health information to specific individuals, companies or organizations under the following circumstances:
   a. All requests must be in writing.
   b. By law we are not required to agree with your restrictions HOWEVER
   c. If we agree with your restrictions, the restriction is binding on us.
2. You have the right to REVOKE your Authorization under certain conditions:
   a. It must be in writing.
   b. The request will not be honored if we have already released your private health information before we received your request to revoke the authorization.
   c. If you were required to give your authorization as a condition of obtaining insurance, the insurance may have the right to your private health information should they decide to contest any of your claims.

I have read your consent policy and agree to its terms.
I also acknowledge that once I sign this consent form I will receive a copy of this completed form for my own records.

Printed Patient Name	Printed Authorized Provider Name
Signature	Signature
Month/Day/Year	Month/Day/Year