BROWNSBORO ROAD CHIROPRACTIC

Dr. Brian Marquez **REGISTRATION AND HISTORY** **DATE:**

Name						**SS#**			
ADDRESS						**DOB**	- -	**Age**	
CITY		**STATE**		**ZIP**		**PHONE**		**CELL**	
How did you hear about our office?	**Radio, Friend/family, website, other_____**								

INSURANCE:

Who is responsible for this account:	**Relationship to patient:**
Insurance Id/Member ID:	**Group # :**
Is there a Secondary Insurance?	**Member Id #:**
AUTO ACCIDENT/Workman's Comp: Company:	**Insurance Agent:**
Claim number:	**Phone number of agent:**

Assignment and release: (sign even if Cash Patient)

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Brian Marquez 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.

X_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ **_____**
Date **Relationship to Patient**

CONDITION TOAY:

Reason for your visit today:	
When did your symptoms begin:	
Is this condition getting progressively worse?	**(Circle one) Yes No Unknown**
Rate the severity of your pain on a scale from 1(least pain) to 10 (severe pain)	**1 2 3 4 5 6 7 8 9 10**
Type of Pain:	(Circle all that apply) **Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Other**

Does it interfere with your: (Circle all that apply) **Work Sleep Daily Routine Recreation**

Activities or movements that are painful to perform: (Circle all that apply) **Sitting Standing Walking Bending Lying**

-OVER-

Are you Pregnant? ☐ NO ☐ YES, Due Date_____
Date of Last Period_____

Health History:

Is this condition related to : ☐ Auto Accident ☐ Job Related ☐ Home Injury ☐ Fall

Please describe if other:

What treatment have you already received for your condition:

Name of other doctor(s) who have treated you for this condition and date(s):

Have you had previous Chiropractic treatment? ☐ Yes ☐ NO If yes, name of doctor/clinic:_____
Last date of treatment:_____
Have you ever been in and Auto Accident: ☐ Yes ☐ No (If Yes, ☐ Past Year ☐ Past 5 Years ☐ Over 5 Years ☐
Describe:

DATE OF LAST:						
Physical Exam:		Spinal Exam:		X-Ray		

ADDITIONAL HISTORY:

Injuries/Surgeries you have had:	Description:	Date:
Fall:		
Head Injury (ies):		
Broken Bones/ Dislocations:		
Surgery (ies):		

Please List: (If you have on a paper/card, we can make a copy)

Medications , Vitamins/Herbs/Minerals ,Allergies:

Please check appropriate box:				Habits :
Exercise:		Work Activity:		☐ High Stress Level Reason_____
☐ None	☐ Moderate	☐ Sitting	☐ Standing	☐ Smoking Packs/Day _____
☐ Daily	☐ Heavy	☐ Light Labor	☐ Heavy Labor	☐ Alcohol Drinks/Week _____
				☐ Coffee/Caffeine Drinks Cup/Day_____

PLEASE CIRCLE TO INDICATE IF YOU HAVE/ HAD ANY OF THE FOLLOWING:

Pneumonia		Mumps		Influenza		Aids/HIV		Heart Disease	
Rheumatic Fever		Polio		Small Pox		Eczema		Mental Disorder	
Pleurisy		Chicken Pox		Arthritis		Thyroid		Anemia	
Tuberculosis		Diabetes		Epilepsy		Measles		Lumbago	
Whooping Cough		Cancer (type):							
Low back pain		Pain between shoulders		Neck pain		Arm pain		Gas/Bloating	
General Stiffness		Joint Pain/Stiffness		Difficulty chewing/ clicking Jaw		Walking problems		Colitis	
Heart Burn		Black/Bloody Stool							
Poor Appetite		Excessive Thirst		Frequent Nausea		Hemorrhoids		Gall Bladder problems	
Vomiting		Diarrhea		Constipation		Abdominal Cramps		Liver problems	
Weight Trouble		Sexually transmitted diseases		Aids/HIV (tested positive)					
Bladder Trouble		Discolored Urine		Painful/Excessive Urination					
Nervous		Numbness		Paralysis		Stress		Convulsions	
Dizziness		Forgetfulness		Confusion/ Depression		Cold/Tingling Extremities		Fainting	
Vision Problems		Dental Problems		Sore Throat		Stuffed Nose		Hearing Problems	
Ear Aches									
Chest Pain		Short of Breathe		Blood Pressure problems		Stroke		Congestion	
Irregular Heartbeat		Heart Problems		Lung Problems		Ankle Swelling		Varicose Veins	

Health Care Authorization Form/HIPPA

Patient Name: _____ **SS#** _____

DOB: _____

The patient identified above, authorizes Brownsboro Road Chiropractic to use and or disclose protected health information in accordance with the following:

- I give permission to Brownsboro Road Chiropractic to use my address, phone numbers, and clinical records to contact me with appointment reminders, missed appointment notifications, birthday/holiday cards, information about treatment alternatives or other health information.
- If Brownsboro Road Chiropractic contacts me by phone, I give permission to leave a phone message on my answering machine, voicemail or with my family.
- I give Brownsboro Road Chiropractic permission to treat me in an open room therapy where other patients are also being treated.
- By signing this form you are giving Brownsboro Road Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

Right to Revoke Authorization

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this authorization is not to the extent that we have provided services or taken in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of Brownsboro Road Chiropractic. The written notice must contain the following information: Name, SS#, Date of Birth, a clear statement of your intent to revoke this authorization, the date of your request and your signature.

This revocation is not effective until it is received by the Privacy Official.

This authorization is requested by Brownsboro Road Chiropractic for its own use/disclosure of Personal Health Information. (Minimal necessary standard apply).

You have the right to inspect or copy the Personal Health Information to be used/disclosed.

***** A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED UPON REQUEST*****

Print Patient Name:_____Date:_____

Signature of patient: _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: the doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous strain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon sever injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritations, burns, or minor complications.

Probability of Risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered:

- Over-the-counter analgesics. The risk of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases
- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases
- Surgery in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal nobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make further rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me.

Printed Name	Signature	Date
Witness printed name	Signature	Date