



Chiro-Med REGISTRATION FORM

Patient Agreement

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of Medical expenses to be incurred, I , the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to CHIRO_MED , all medical benefits and /or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator of fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and /or settlement information upon written request from any doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health care benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured/ Guardian

Date



Chiro-Med REGISTRATION FORM

What is your Major complaint ? _____

How long have you had this condition ? _____

Have you had this or similar conditions in the past ? _____

Do any positions make it feel worse ? _____

Do any positions make it feel better ? _____

Is this condition : _____ Improved _____ Unchanged _____ Getting worse

Is this condition interfering with your : _____ Work _____ Sleep _____ Daily Routine _____ Other

Other doctors or therapist who have treated THIS CONDITION : _____

What do you think caused this condition ? _____

List surgical operations and years: _____

Medications, dosage and frequency: _____

Have you been in an automobile accident or had any other personal injury ? _____ Yes _____ No

Describe: _____

Signature

Date

Parent / Guardian Signature

Date

Patient Name

Number

Date



Chiro-Med PATIENT HISTORY FORM

(Check only the ones you now have or have had in the past)

GENERAL	NOW	PAST	THROAT	NOW	PAST	GASTROINTESTINAL	NOW	PAST
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
SKIN			NECK			Irregular Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Masses	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>	BREASTS			Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
HEAD			Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY		
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Bumps	<input type="checkbox"/>	<input type="checkbox"/>	Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Last Eye Exam			Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>	Straining	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>	LUNGS			Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stones	<input type="checkbox"/>	<input type="checkbox"/>
EARS			Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Small Stream	<input type="checkbox"/>	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	HEART			Urine Color _____		
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Spotting Between		
NOSE			Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Periods	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>	Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Contraception Type _____		
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD			Age at First Period _____		
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Cycle _____		
MOUTH			Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Flow _____		
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	No. of Pregnancies _____		
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	No. of Births _____		
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>	No. of Miscarriages _____		
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>	No. of Abortions _____		
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Sugar in Blood	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Flow <input type="checkbox"/> Heavy <input type="checkbox"/> Mod <input type="checkbox"/> Light		
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Red Spots	<input type="checkbox"/>	<input type="checkbox"/>	Last Period _____		
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>				Last Pap Smear _____		
Blisters	<input type="checkbox"/>	<input type="checkbox"/>				Last Vaginal Exam _____		
						Last Mammogram _____		
						Last Prostate Exam _____		



Chiro-Med PATIENT HISTORY FORM

NEUROLOGIC NOW PAST

- Seizures
- Vertigo
- Dizziness
- Hand Trembling
- Loss of Sensation
- Incoordination
- Loss of Facial
- Weak Grip
- Paralysis
- Difficulty Speech
- Tingling
- Loss of Memory
- Numbness

ENDOCRINE

- Weight Loss
- Weight Gain
- Extremely Thin
- Heat Intolerance
- Cold Intolerance
- Hair Changes
- Breast Changes

IMMUNIZATION/VACCINATION

- DPT
- Mumps
- Smallpox
- Typhoid
- Tetanus
- Measles
- Pneumococcal
- Influenza
- Polio
- MMR

BLOOD TYPE

- A + A -
- B + B -
- AB + AB -
- O + O -
- Other _____

BLOOD TRANSFUSIONS

- Date _____
- Date _____
- Date _____
- Date _____

PSYCHIATRIC NOW PAST

- Hyperventilation
- Insecurity
- Depression
- Troubled Sleep
- Irritable
- Undecidedness
- Timid
- Hallucinations
- Loss of Memory
- Alcoholism
- Drug Addiction
- Drug Dependent
- Suicidal Thoughts
- Extreme Worry
- Sexual Problems

PAST MEDICAL HISTORY. Check only the ones you have had in the past.

- | | |
|--|--|
| Hay Fever <input type="checkbox"/> | Parasites <input type="checkbox"/> |
| Mumps <input type="checkbox"/> | Epilepsy <input type="checkbox"/> |
| Rheumatic Fever <input type="checkbox"/> | Paralysis <input type="checkbox"/> |
| Allergies <input type="checkbox"/> | Polio <input type="checkbox"/> |
| Angina <input type="checkbox"/> | Mental Illness <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Alcoholism <input type="checkbox"/> |
| Tumor <input type="checkbox"/> | Depression <input type="checkbox"/> |
| Blood Disease <input type="checkbox"/> | Nervous Breakdown <input type="checkbox"/> |
| Leukemia <input type="checkbox"/> | Migraine <input type="checkbox"/> |
| Heart Trouble <input type="checkbox"/> | Gout <input type="checkbox"/> |
| Varicose Veins <input type="checkbox"/> | Hemorrhoids <input type="checkbox"/> |
| Phlebitis <input type="checkbox"/> | Prostate Problems <input type="checkbox"/> |
| Hypertension <input type="checkbox"/> | Sexual Problems <input type="checkbox"/> |
| Stroke <input type="checkbox"/> | Gonorrhea <input type="checkbox"/> |
| Ulcers <input type="checkbox"/> | Syphilis <input type="checkbox"/> |
| Jaundice <input type="checkbox"/> | Diabetes <input type="checkbox"/> |
| Skin Trouble <input type="checkbox"/> | Bladder Trouble <input type="checkbox"/> |
| Gallstones <input type="checkbox"/> | Kidney Stones <input type="checkbox"/> |
| Liver Trouble <input type="checkbox"/> | Kidney Infections <input type="checkbox"/> |
| Hepatitis <input type="checkbox"/> | Dysentery <input type="checkbox"/> |

Date of Last Chest X-Ray _____ Normal Abnormal

Last TB Skin Test _____ Normal Abnormal

Allergies: _____



Chiro-Med PATIENT HISTORY FORM

FAMILY HISTORY (List any of the diseases listed above which run in your family)

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____

SOCIAL HISTORY (Check the boxes and fill in)

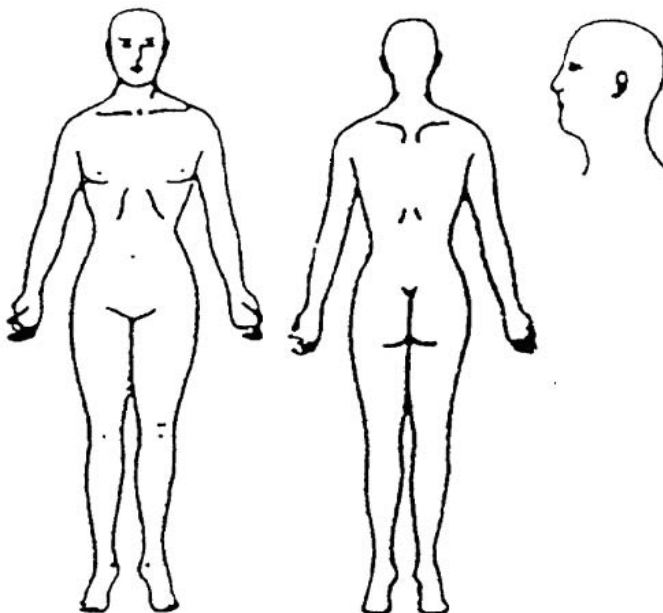
Current Weight _____ Have you recently lost or gained weight? _____ Mental Work Heavy Moderate Light Hours per day _____ Physical Work Heavy Moderate Light Hours per day _____ Exercise Heavy Moderate Light Hours per week _____ Type _____ Smoking Current Previous Packs/Day _____ # of years _____ Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ # of Years _____ Caffeine Cups/Day _____ # of Years _____

(Coffee, Tea, Cola)

Aspirin # per Day _____ # of Years _____ Others _____

Please fill out this form as accurately as possible. Mark the area(s) on the body diagram where you feel your described symptom(s). Use the appropriate symbol(s) to mark areas of the body. Include all affected areas.

- Aches = ○
- Numbness = ▲
- Pins/Needles = □
- Burning Sensation = x
- Stabbing Sensation = /



Indicate the severity of your symptoms by marking an "X" on the lines below:

How bad are your symptoms now?

None _____ Severe

How bad have your symptoms been in the past?

None _____ Severe



Chiro-Med PATIENT CONSENT FORM

PATIENT CONSENT

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of the diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:

By signing this form, you are granting consent to **CHIRO-MED** to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at **(618) 235-3200**. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to evoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and / or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

FEMALE PATIENTS ONLY: VERIFICATION OF NON-PREGNANCY

By my signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period_____.

X _____
Print Patient's name

X _____
Patient's Signature

X _____
Other than Patient, Print Name & Relationship

X _____
Witness

ALL OTHER PATIENTS: Please Sign here

X _____
Print Patient's name

X _____
Patient's Signature

X _____
Other than Patient, Print Name & Relationship

X _____
Witness