PATIENT REGISTRATION

Date________________________

Last Name___________________________ First Name_______________________ MI__________

Street Address____

City__________________________________State_____________ Zip Code____________________

Social Security #________________-__________-_________________

Email Address____

Home Phone(_______) _______________________ Cell Phone(_______) _____________________

Sex ◻ Male ◻ Female Date of Birth______________________________ Age_____________

Marital Status ◻ Married ◻ Single ◻ Divorced ◻ Widowed ◻ Partnered ◻ Minor

Patient Employer/School____

Occupation______________________________ Employer Phone(_____) _____________________

Employer/School Address____

Spouse's Name____

Spouse's Employer____

In Case Of Emergency, Contact:

Name______________________________________Relationship_______________________________

Home Phone (_______) ______________________ Cell Phone(________) _____________________

Are any of your family members or friends in need of chiropractic care? ◻ Yes ◻ No

Ortega Chiropractic
& Medical Rehab

Ortega Chiropractic Corp.- 5367 ORTEGA Boulevard- Jacksonville, FL 32210

(904) 425-4545

HEALTH HISTORY

What treatment have you already received for your condition? ◻ Medication ◻ Surgery

◻ Physical Therapy ◻ Chiropractic ◻ None ◻ Other ___________________________________

Name of other doctor(s) who you have seen for this condition ____________________________

Date of Last:

Physical Exam __________ X-ray _________ MRI/CT __________

Please Circle if you have had any of the following:

AIDS/HIV	Chicken Pox	Liver Disease	Rheumatoid Arthritis
Alcoholism	Diabetes	Measles	Rheumatic Fever
Allergies	Emphysema	Migraines	Scarlet Fever
Anemia	Epilepsy	Miscarriage	Stroke
Anorexia	Fractures	Multiple Sclerosis	Suicide Attempt
Appendicitis	Glaucoma	Mumps	Thyroid Problems
Arthritis	Goiter	Osteoporosis	Tonsillitis
Asthma	Gout	Pacemaker	Tuberculosis
Bleeding Disorders	Heart Disease	Parkinson’s	Tumors, Growths
Breast Lump	Hepatitis	Pinched Nerve	Typhoid Fever
Bronchitis	Hernia	Pneumonia	Ulcers
Bulimia	Herniated Disc	Polio	Vaginal Infections
Cancer	Herpes	Prostate Problem	Venereal Disease
Cataracts	High Cholesterol	Prosthesis	Whooping Cough
Chemical Dependency	Kidney Disease	Psychiatric Care	Other

Exercise: ◻ None ◻ Moderate ◻ Daily ◻ Heavy

Work Activity: ◻ Sitting ◻ Standing ◻ Light ◻ Heavy

Habits: ◻ Smoking ◻ Alcohol ◻ Coffee/Caffeine

List Surgeries and Dates____

____

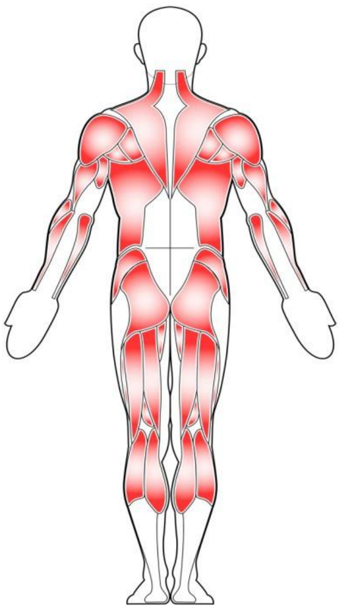
Medications____

Name:________________________________ Date:________________

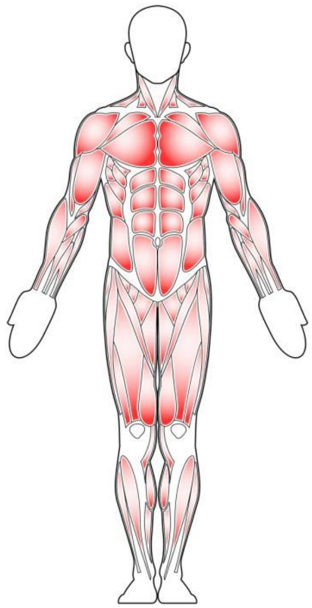
Pain Evaluation

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_______

Please mark an “x” on the picture where you have pain, numbness, or tingling.



Left Back Right



Right Front Left

When did your symptoms first appear?_______________________________________

Is this condition getting progressively worse? □ Yes □ No

Type of Pain: □ Sharp □ Dull □ Burning □ Shooting □ Stiffness □ Aching
□ Tingling □ Cramping □ Numbness □ Swelling □ Other

Is this pain constant? □ Yes □ No

How does this condition impact your……….

a) Home Life____

b) Work Life____

c) Social Life____

Rate your commitment to fix this problem on a scale of 1(none) to 10(total) __________

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefits may, also provide some level of risk. This level of risk is most often very minimal; yet in rare cases, injury has been associated with chiropractic care. These types on complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disk condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at adjustments, may be veritable artery injury that could lead to stroke.

Prior to receiving chiropractic care at this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

___________________________ ___________________________

Patient Name (printed) Relationship to Patient

___________________________ ___________________________

Patient or legal Guardian (signature) Date

___________________________ ___________________________

Witness Signature (office staff) Date

Ortega Chiropractic

5367 Ortega Blvd
Jacksonville, FL 32210
904-425-4545
904-425-4548 Fax

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

Dated: ______________________________

____
Patient or Patient's Representative

____
Print Patient's Name

____
If signed by Representative, state name of Representative

____
Relationship to Patient