Hardison Family Chiropractic

Patient Registration

Patient Data:

First Name:_____ Middle Initial:_____ Last Name:_____

Preferred Name:_____ Suffix:_____ Gender: [ ] Male [ ] Female

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone: (____)_____-_____ Work Phone: (____)_____-_____

Cell Phone: (____)_____-_____ Preferred Contact #: (*circle one*) Home Work Cell

Occupation:_____ Employer:_____

Email Address:_____

Date of Birth:_____/_____/_____ Age: ____

Marital Status: [ ] Married [ ] Single

Emergency Contact:_____ Emergency Contact #: (____)_____-_____

Have you ever been to a chiropractor before this visit? [ ] Yes [ ] No

If so, where?_____

How Did You Hear About Us?_____

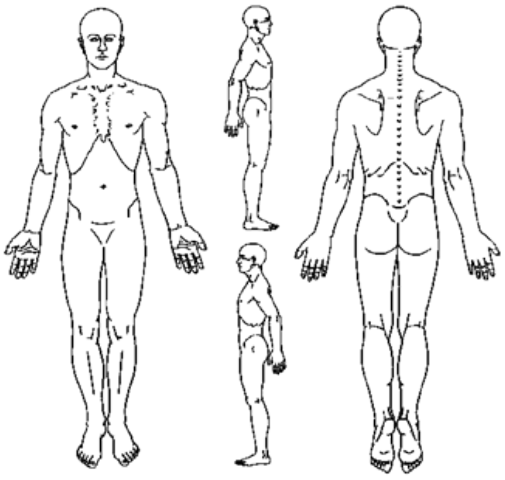
Patient Condition:

Primary Concern:_____

When did symptoms first occur?_____

Is this a recurring condition?_____

Please mark where the symptoms typically occur on the image shown below.



Rate the severity of your pain on a scale of 1 (*least pain*) to 10 (*severe pain*): _____

What type of pain is occurring in affected areas? (*circle all that apply*)

[Sore Dull Sharp Aching Stabbing Burning Numbness Tingling]

How often are you affected by the pain?_____

Have you ever received previous care for this condition?_____ When?_____

Is the condition getting worse? [ ] Yes [ ] No [ ] Unknown

Does it interfere with any of the following? (*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 Down]

Doctor's Comments

_____

_____

_____

_____

Health Review Form:

Do you drink alcohol? [ ] Yes [ ] No If yes, how often?_____

Do you smoke cigarettes? [ ] Yes [ ] No If yes, how many packs per day?_____

Do you use other drugs? [ ] Yes [ ] No If yes, which ones?_____

How many hours do you sleep during the night?_____ Are you pregnant? [ ] Yes [ ] No

Have you suffered any prior major illnesses? [ ] Yes [ ] No If yes, please describe_____

_____

Do you take any medications? [ ] Yes [ ] No If yes, which ones?_____

_____

_____

Injuries/Surgeries you have had…

Auto accidents/Other accidents/Falls:_____ Date:_____

Head Injuries:_____ Date:_____

Surgeries:_____ Date:_____

Do you have any of the following? *Check all that apply.*

General:

[ ] Unintentional weight gain/loss

[ ] Fever

[ ] Fatigue

[ ] Night sweats

[ ] Loss of appetite

[ ] Difficulty sleeping

Eye:

[ ] Blurry or double vision

[ ] Loss of vision

Ear, Nose, and Throat:

[ ] Hearing problems

[ ] Ringing in the ears

[ ] Sinus problems

[ ] Difficulty swallowing

[ ] Neck swelling

[ ] Hoarseness

Heart:

[ ] Chest pain

[ ] Rapid or irregular heart beat

[ ] Passing out or loss of consciousness

[ ] Swollen feet

Lungs:

[ ] Shortness of breath

[ ] Cough

[ ] Wheezing

[ ] Coughing up blood

Gastrointestinal:

[ ] Hemorrhoids

[ ] Nausea/Vomiting

[ ] Heartburn

[ ] Diarrhea

[ ] Constipation

[ ] Blood in stool

[ ] Black tarry stool

[ ] Change in bowel movements

Musculoskeletal:

[ ] Joint pain

[ ] Joint swelling

Skin:

[ ] Concerning moles

[ ] Rash

[ ] Itching

Neurological:

[ ] Dizziness

[ ] Numbness

[ ] Tremor

[ ] Unsteady walking

Endocrine:

[ ] Swollen hands/fingers

[ ] Excessive thirst

[ ] Large amounts of urine

Lymphatic/Hematological:

[ ] Swollen glands

[ ] Easily bruised

[ ] Sores that do not heal

Psychological:

[ ] Anxiety

[ ] Depression

[ ] Panic attacks

Allergic/Immunologic:

[ ] Sneezing

[ ] Watery eyes

Urinary:

[ ] Incontinence

[ ] Urgency

[ ] Difficulty urinating

[ ] Frequent urination

Doctor's Signature:_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance with the previously listed insurance company and assign directly, to Dr. Hardison, 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 Dr. Hardison to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient (*or Responsible party*)'s Signature:_____

Relationship (*if not patient*):_____ Date:_____

Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the Dr. Todd Hardison and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Dr. Todd Hardison and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Patient/Parent/Guardian:

Printed Name:_____ Date:_____

Signature:_____

Witness:

Printed Name:_____ Date:_____

Signature:_____