Neighborhood Chiropractic and Acupuncture LLC
Registration and History

PATIENT INFORMATION

Last Name:	Date:
First Name	Middle Initial:
Address:	
City:	State: Zip:
Cell Phone Number:	Home Phone Number:
Email:	May we send you e-mail correspondence? ○Yes ○No
Sex ○M ○F	
○ Single ○Married ○Divorced ○Widowed ○Minor	
Birthdate:	Age:
Occupation:	
Patient Employer and/or School:	
Work Phone Number:	May we call you at work? ○Yes ○No
Who is responsible for this account? ○Self ○Insurance Company ○Guardian Name:	
Who do we thank for referring you?	

In Case of Emergency, Contact

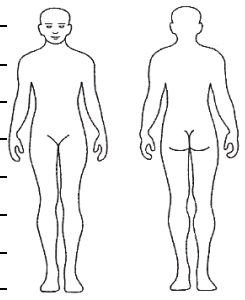
Name:	Relationship:
Home Phone:	Work Phone:
Primary Care Physician:	Phone Number:

ACCIDENT INFROMATION

Is this condition due to an accident? ○Yes ○No	Date of Accident:
Type of Accident: ○Auto ○Work ○Home ○Other:	
To whom have you made report of your accident? ○Auto Insurance:	
○Employer ○Worker Comp. ○Other:	
Claim # (if applicable):	Attorney Name (if applicable):

PATIENT CONDITION

Reason for your visit
When did your symptoms appear?
Is this condition getting progressively worse? ○Yes ○No ○Don't Know
Mark an X on the picture where you have pain, numbness, or tingling.
Areas of your body that need special attention? ○Yes ○No ○Describe:
Rate the severity of pain from 1 (least pain) to 10 (most pain):
Type of pain: ○Sharp ○Dull ○Throbbing ○Numbness ○Aching ○Shooting ○Burning
○Tingling ○Cramps ○Stiffness ○Swelling ○Other (describe):
Location of numbness or tingling:
How often do you have these symptoms?
Is it constant or does it come and go?
Does it interfere with your: ○Work ○Sleep ○Daily Routine ○Recreation
Activities that are painful: ○Sitting ○Standing ○Walking ○Bending ○Lying Down ○Lovemaking ○Other
Are you experiencing any other symptoms in your body?



HEALTH HISTORY

Name:	Date:
What treatment have you already had for your condition? ○Medications ○Surgery ○ Physical Therapy ○Chiropractic Services ○None ○Other:	
Name of other practitioners who have treated you for this condition:	
Have you ever had chiropractic care? ○Yes ○No	Massage? ○Yes ○No Acupuncture? ○Yes ○No
Date of Last: Physical Exam:	X-ray (Area): Lab Work:
Spinal Exam:	MRI, CT-Scan or Bone Scan:

Place a mark in the box to indicate if you have had any of the following:

- o AIDS/HIV
- o Allergies to oils/ fragrance
- o Anemia
- o Arm/ Hand Pain
- o Arthritis
- o Asthma
- o Bleeding Disorders
- o Blood clots
- o Cancer
- o Cataracts
- o Chemical Dependency
- o Chicken Pox
- o Communicable disease
- o Contacts
- o Diabetes
- o Dizziness
- o Eating Disorder
- o Easy Bruising
- o Emphysema
- o Epilepsy/ seizures
- o Fainting
- o Fibroids
- o Fibromyalgia
- o Glaucoma
- o Gonorrhea
- o Headaches
- o Hearing Difficulty
- o Heart Disease
- o Hepatitis
- o Herniated Disc
- o Hernia
- o High Cholesterol
- o Jaw Problems
- o Kidney Disease
- o Leg/Foot Disease
- o Liver Disease
- o Low Back Problems
- o Low Blood Pressure
- o Multiple Sclerosis
- o Neck Pain/ Stiffness
- o Open cuts or sore
- o Osteoporosis
- o Pacemaker
- o Parkinson's disease
- o Pinched Nerve
- o Pneumonia
- o Polio
- o Prosthesis
- o Psychiatric Care
- o Respiratory Problems
- o Rheumatoid Arthritis
- o Rheumatic Fever
- o Sciatica
- o Shoulder Problems
- o Skin Disease
- o Stroke
- o Thyroid Problems
- o Transient Ischemic Attack (TIA)
- o Tuberculosis
- o Tumors/ Growths
- o Typhoid
- o Ulcers
- o Varicose Veins
- o Venereal Disease

□Other condition not listed above:

Exercise: ○None ○Moderate ○Daily ○Heavy Describe:
Work Activity: ○Sitting ○Standing ○Light Labor ○Heavy Labor
Habits: ○Smoking: # Cigarettes or Packs/day? ____ How many years? ___ Were you ever a smoker? ○Yes ○No ○Alcohol: # Drinks/week? ____ ○Caffeine Drinks # Cups/Day? ____ ○High Stress Level Reason:
Women: Are you pregnant? ○Yes ○No Due Date: Number of children:

Injuries/ Surgeries (Include a date and a description):

Falls:
Head Injuries:
Broken Bones:
Dislocations:
Surgeries:
Car Accidents:

Family Health History

Has anyone in your immediate family had the following conditions? (including grandparents):
○Heart Disease ○Stroke ○Cancer ○Diabetes ○Other Describe any selected:
○Other Family Diseases:

Medications:	For what condition?
Vitamins/Herbs/Supplements:	
Allergies:	

Is there anything else you would like to share with your doctor?

Neighborhood Chiropractic
and Acupuncture LLC

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HIPAA Policy – Acknowledge of Receipt of Notice of Privacy Practices

I, _____ acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practice of Neighborhood Chiropractic and Acupuncture which describes the Practice policies and procedures regarding the use and disclosure of any of my Protected Health information created, received, or maintain by the Practice.

Missed/ Cancellation Policy

When you make an appointment, you're paying for the practitioner's time. Appointments require a 24-hour cancellation notice. We are unable to bill insurance companies for missed appointments. ***Those who repeatedly miss appointments will be asked to pay $25 fee for missed/cancelled appointments without 24-hour notice.*** Thank you for your understanding of this matter.

Communication Consent

Here at Neighbor Chiropractic and Acupuncture LLC, we are adding different options for communication to allow to have better access to your medical records, billing, and appointments. In order to communicate information regarding your care, account, appointments, and the clinic, we need permission to do so. We will never sell any of your information, nor use it for marketing purposes.

I, _____ authorize Neighborhood Chiropractic to contact me and/or named authorized person(s) and to convey Personal Health Information by the following methods and assume responsibility to notify Neighborhood Chiropractic whenever this information changes.

Text Message Reminders: ____Yes Text: _____
____No, Provider may only leave a name and phone number.

Detailed Voicemail: ____Yes Phone: _____
____No, Provider may only leave a name and phone number.

Detailed Email: ____Yes Email: _____
____No, provider may not contact me by email.

Email Billing: ____Yes Email: _____
____No, I prefer billing statements/ correspondence to be mailed in paper form.

Please list names & relationships of other people authorized to receive information about your care:

_____

I hereby attest the above information is correct, and that I have read and understood the above policies.

Print Name: _____ Date: _____

Signature: _____