Chiropractic Registration and History

PATIENT INFORMATION

Date: _____

Name: _____
Last name

_____
First name Middle initial

Address: _____

City: _____

State: _____ Zip: _____

Email: _____

Sex: □ Male □ Female Age: _____

Birthdate: _____

□ Married □ Widowed □ Single □ Minor

□ Separated □ Divorced □ Partnered

Employer/School: _____

Address: _____

_____

Whom may we thank for referring you? _____

CONTACT INFORMATION

Home Phone: _____ Cell: _____

Best time to reach you: _____

Emergency Contact**:** _____

Relationship: _____ Number: _____

ACCIDENT INFORMATION

Is condition due to an accident: □ Yes □ No Date: _____

Type of accident: □ Auto □ Work □ Home □ Other

To whom have you made a report of your accident to?

□ Auto Insurance □ Employer □ Worker Comp □ Other

Attorney (if applicable): _____

PATIENT CONDITION

Reason for visit: _____

_____

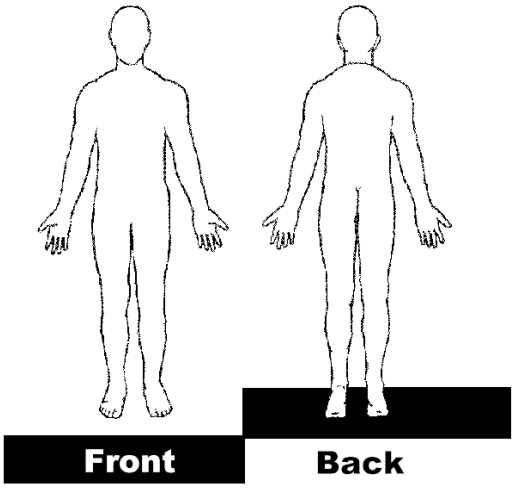
When did your symptoms appear: _____

_____

Is this condition progressively getting worse?

□ Yes □ No □ Not sure

Mark an X on the picture(s) below where you have pain, numbness, tingling, etc.



Rate the severity of the pain on a scale from 1 (least pain) to

10 (severe pain): _____

Type of pain:
□ Sharp □ Throbbing □ Dull □ Aching □ Cramping

□ Burning □ Tingling □ Stiff □ Shooting □ Other

How often do you have this pain? _____

Is it constant or comes and goes? _____

Does it interfere with: □ Work □ Sleep □ Daily Routine

□ Recreation □ Other _____

Activities that are painful to perform: □ Sitting □ Standing

□ Walking □ Bending □ Lying down □ Turning

- OVER -

HEALTH HISTORY

What treatment have you already received for your condition? □ Medications □ Surgery □ Physical therapy

□ Chiropractic care □ None □ Massage □ Other _____

Name and location of other physicians who have treated you for your condition _____

Date of last: Physical exam _____ Spinal x-ray _____ Blood test _____

Spinal exam _____ Chest x-ray _____ Urine test _____

Dental x-ray _____ MRI, CT-scan, Bone scan _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	□ yes □ no	Chicken pox	□ yes □ no	Liver Disease	□ yes □ no	Rheumatoid arthritis	□ yes □ no
Alcoholism	□ yes □ no	Diabetes	□ yes □ no	Measles	□ yes □ no	Rheumatic fever	□ yes □ no
Allergy shots	□ yes □ no	Emphysema	□ yes □ no	Migraines	□ yes □ no	Scarlet fever	□ yes □ no
Anemia	□ yes □ no	Epilepsy	□ yes □ no	Miscarriage	□ yes □ no	Stroke	□ yes □ no
Anorexia	□ yes □ no	Fractures	□ yes □ no	Mononucleosis	□ yes □ no	Suicide attempt	□ yes □ no
Appendicitis	□ yes □ no	Glaucoma	□ yes □ no	Multiple Sclerosis	□ yes □ no	Thyroid problems	□ yes □ no
Arthritis	□ yes □ no	Goiter	□ yes □ no	Mumps	□ yes □ no	Tonsillitis	□ yes □ no
Asthma	□ yes □ no	Gonorrhea	□ yes □ no	Osteoporosis	□ yes □ no	Tuberculosis	□ yes □ no
Bleeding disorders	□ yes □ no	Gout	□ yes □ no	Pacemaker	□ yes □ no	Tumors/Growths	□ yes □ no
Breast lump	□ yes □ no	Heart Disease	□ yes □ no	Parkinson's	□ yes □ no	Typhoid fever	□ yes □ no
Bronchitis	□ yes □ no	Hepatitis	□ yes □ no	Pinched nerve	□ yes □ no	Ulcers	□ yes □ no
Bulimia	□ yes □ no	Hernia	□ yes □ no	Pneumonia	□ yes □ no	Vaginal Infections	□ yes □ no
Cancer	□ yes □ no	Herniated disc	□ yes □ no	Polio	□ yes □ no	Venereal disease	□ yes □ no
Cataracts	□ yes □ no	Herpes	□ yes □ no	Prostate problems	□ yes □ no	Whooping cough	□ yes □ no
Chemical		High cholesterol	□ yes □ no	Prosthesis	□ yes □ no	Other _____	
dependency	□ yes □ no	Kidney disease	□ yes □ no	Psychiatric care	□ yes □ no	_____	

EXERCISE

□ None
□ Moderate
□ Daily
□ Heavy

WORK ACTIVITY

□ Sitting
□ Standing
□ Light labor
□ Heavy labor

HABITS

□ Smoking packs/day _____
□ Alcohol drinks/week _____
□ Coffee/caffeine cups/day _____
□ High stress level reason _____

Are you pregnant? □ yes □ no Due date: _____

Injuries/Surgeries

Falls _____

Head injuries _____

Broken bones _____

Dislocations _____

Surgeries _____

MEDICATIONS

_____
_____
_____
_____
_____

ALLERGIES

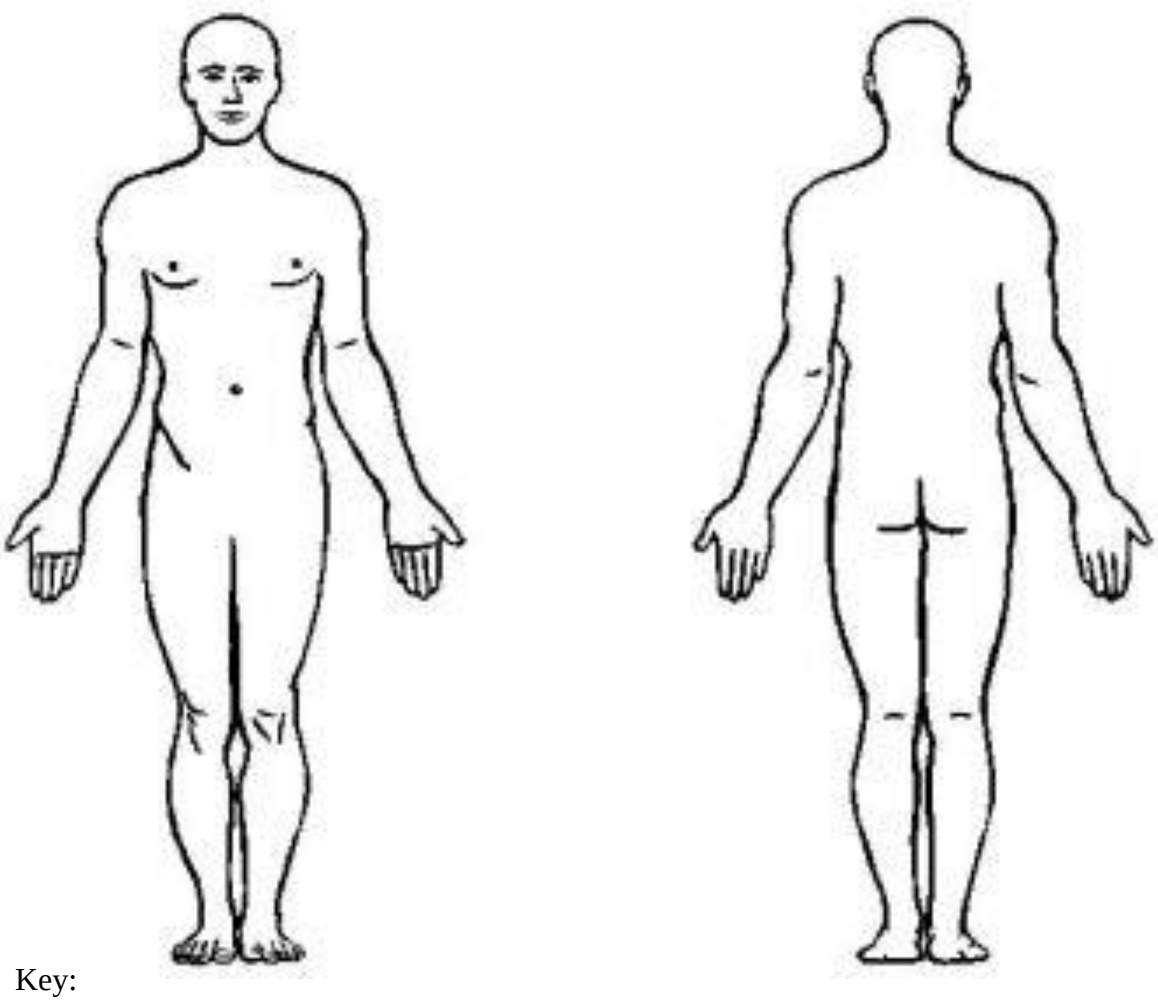
_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

Name:

Pain Diagram



Key:

^^^ - Ache	ooo – Numbness	/// - Sharp/Stabbing
=== - Burning	… - Pins and Needles	xxx - Other

Pain Rating (0/10)

_____ ____/10

_____ ____/10

_____ ____/10

_____ ____/10

Signature: _____ Date: _____

Gatto Chiropractic

Name:

Chiropractic Informed Consent

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. Following are the known risks:

Temporary soreness or increased symptoms or pain. It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments. This is usually due to muscle soreness and/or minor joint inflammation.

Dizziness, nausea, flushing. These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

Fractures. When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

Disc herniation or prolapse. Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen. A more conservative chiropractic approach is generally taken in order to lessen chances of making disc conditions worse.

Stroke. A specific, extremely rare, type of stroke has been associated with chiropractic care. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care compared to medical treatment. In fact, the incidence of a chiropractic adjustment induced stroke is 1:1-20 million. Occurrence of this type of stroke is associated to an underlying cardiovascular condition.

Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.

I understand and acknowledge that there are risks as well as benefits of chiropractic care. I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

_____

Name of Patient

_____ _____

Signature of Patient or Guardian Date

_____ _____

Signature of Chiropractor Date