FALL CHIROPRACTIC REGISTRATION FORM

Date_____Home Phone_____CellPhone_____

Email_____ I accept ☐ receipt of monthly e-newsletters with office closure announcements.

Last Name_____First Name_____ Middle Initial_____

Street Address_____

City_____State_____Zip_____

Sex ☐ Male ☐ Female Age_____ Birth Date_____Occupation_____

Are you: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Who referred you to this office? _____

T-shirt Size (while supplies last):_____ Do you have Medicare? ☐ **Yes** ☐ **No**

PARENTAL CONSENT TO EVALUATE AND TREAT A MINOR

I _____, being the parent/legal guardian of _____
Hereby grant permission for my child to receive chiropractic care.

Witness_____

CONSENT TO INITIATE CARE

At our office, we have one simple goal--we want to render the highest quality Chiropractic care at the lowest possible fee. In order to accomplish this goal, we have altered some of our business procedures to keep our fees reduced. Please read over these procedures below to understand how our office functions, and to decide if you wish to participate. If you have any questions, please direct them to the receptionist.

- You may choose to submit receipts to your insurance company or other third-party health care programs, but payment for such services by insurance companies is neither implied nor agreed to by this office. We take *no responsibility* for non-payment by insurance companies for services rendered at our office.
- Our office will not respond to any requests for paperwork for insurance purposes or even acknowledge insurance requests for information on any patient's case, However, patients may have a copy of their records at any time they request.
- No balances can be kept or run by patients at any time.
- All adjustment visits are paid immediately prior to the service being rendered.
- All initial visits, scans, or x-rays (if necessary) are paid for upon completion of these services.
- Our office reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served.

I wish to initiate care at this office. I have read and understand the Consent to Initiate Care and agree to all terms. I understand that I am under no obligation to receive or continue care.

Print your name:_____Today's Date:_____

Sign your name:_____

SOME QUESTIONS TO HELP US HELP YOU

Name:_____ Date:_____

If we could only help you with one health problem, what would that be?

_____

_____

What other health problem would you like us to help you with?

_____

_____

How did these problems start?

_____

_____

When did these problems begin?_____

Have you ever had these problems before?_____

Is it worse in the morning or at night? (check one) ☐ **Morning** ☐ **Night**

Do you ever have numbness, tingling or pain in the arms or legs?_____

How often do you feel the pain and how long does it last?_____

Please list any other doctors seen for the above problem:_____

Please list medications you are currently taking:_____

Please list any surgeries you have had:_____

Please list any auto or work accidents you have had:_____

Please indicate family history of: ☐ **Heart Disease** ☐ **Diabetes** ☐ **Arthritis** ☐ **Cancer** ☐ **Back Problems**

Do you have dizziness? ☐ **Yes** ☐ **No** Do you have heart, lung, or stomach problems? ☐ **Yes** ☐ **No**

Are you ☐ **right or** ☐ **left** handed? How tall are you?_____ How little do you weigh?_____

Name of previous chiropractor(s)?_____

When were the last time x-rays were taken?_____

Are you looking for ☐ **temporary relief or** ☐ **full correction** of the cause of your problem?

Why:_____

What activities or hobbies have you been unable to do because of your problem?_____

WORK INJURY & AUTOMOBILE INJURY NOTICE AND PURPOSE OF AN ADJUSTMENT DISCLOSURE

By signing below, I acknowledge that I am aware that Fall Chiropractic and Dr. Bryan Fall do **not** provide care for **work-related injuries, automobile accident injuries, or personal injuries**. I also acknowledge that I must inform this office if I am in an automobile or work-related injury and must seek care at my medical doctor's office or another healthcare provider for injuries or conditions sustained. I also am completely aware that Fall Chiropractic and Dr. Bryan Fall will not bill, submit claims, nor prepare or submit reports for any automobile, personal or work-related injury. I also understand that I am responsible to pay each visit myself at the time of service.

Further I understand that chiropractic care is given to correct misalignments of the spine called SUBLUXATIONS. One of the benefits of a chiropractic adjustment is that you MAY feel better but this is not the GOAL of an adjustment. The goal of an adjustment is to correct SUBLUXATIONS, thereby removing the interference to the nervous system allowing the body to heal itself. As a result, **WE DO NOT TREAT PAIN OR DISEASE; we remove subluxations so that the body is able to function properly and be better enabled to heal itself.**

Signed:_____

Please Print Name:_____

Date:_____

Name:_____ Date:_____

MUSCULO-SKELETAL
☐ Low back problems
☐ Pain between the shoulders
☐ Neck problems
☐ Arm problems
☐ Leg problems
☐ Swollen joints
☐ Painful joints
☐ Stiff joints
☐ Sore muscles
☐ Weak muscles
☐ Walking problems
☐ Ruptures
☐ Broken bones

GENITO-URINARY
☐ Bladder trouble
☐ Excessive urination
☐ Scanty urination
☐ Painful urination
☐ Discolored urination

FEMALE
☐ Vaginal discharge
☐ Vaginal bleeding
☐ Vaginal pain
☐ Breast pain
☐ Lumps on breast
Pregnant? ☐ Yes ☐ No

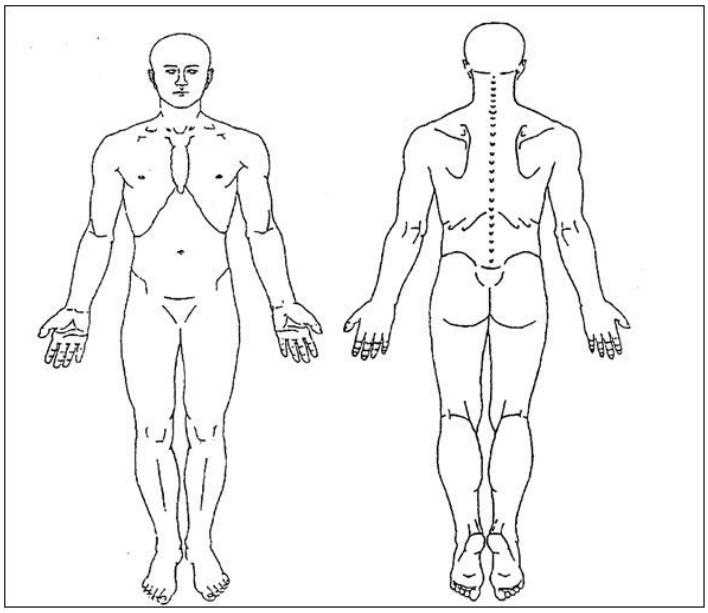
GASTRO-INTESTINAL
☐ Poor appetite
☐ Excessive hunger
☐ Difficulty chewing
☐ Difficult swallowing
☐ Excessive thirst
☐ Nausea
☐ Vomiting food
☐ Vomiting blood
☐ Abdominal pain
☐ Diarrhea
☐ Constipation
☐ Black stool
☐ Bloody stool
☐ Hemorrhoids
☐ Liver trouble
☐ Gall bladder problems
☐ Weight trouble

NERVOUS SYSTEM
☐ Numbness
☐ Loss of feeling
☐ Paralysis
☐ Dizziness
☐ Fainting
☐ Headaches
☐ Muscle jerking
☐ Convulsions
☐ Forgetfulness
☐ Confusion
☐ Depression

CARDIOVASCULAR
☐ Chest pain
☐ Pain over heart
☐ Difficult breathing
☐ Persistent cough
☐ Coughing phlegm
☐ Coughing blood
☐ Rapid heartbeat
☐ Blood pressure problem
☐ Heart problems
☐ Lung problems
☐ Varicose veins

EYES, EARS, NOSE, THROAT
☐ Eye strain
☐ Eye inflammation
☐ Vision problems
☐ Ear pain
☐ Ear noises
☐ Hearing loss
☐ Ear discharge
☐ Nose pain
☐ Nose bleeding
☐ Nose discharge
☐ Difficult breathing through nose
☐ Sore gums
☐ Dental problems
☐ Sore mouth
☐ Sore throat
☐ Hoarseness
☐ Difficult speech

Mark areas on your body where you feel pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed.



Ache **>>>>>**
Dull **000000**
Throbbing **~~~**
Pins & needles
Tingling **+++++**
Sharp ↔↔↔↔
Stabbing **!!!!!!**
Numbness **=====**
Soreness **uuuu**
Shooting ↓↓↓
Burning **xxxxxx**
Other

On a pain scale from 0-10, with 0 being no pain and 10 being severe enough to seek emergency care, which number would describe you pain/discomfort severity? Please circle…

What is your pain/discomfort like today?
0 1 2 3 4 5 6 7 8 9 10

What is your pain/discomfort on average?
0 1 2 3 4 5 6 7 8 9 10

What is your pain/discomfort at its worst?
0 1 2 3 4 5 6 7 8 9 10