FALL CHIROPRACTIC REGISTRATION FORM

Date_____Home Phone_____Cell Phone_____

Email_____ I accept ☐ 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? _____

If needing to communicate your health information, whom can we contact? _____

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:_____

INFORMED 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, and all adjustment visits are paid immediately prior to the service being rendered.
- All initial visits, scans, or 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 the patient's health is not being best served.
- It is understood the doctor will use his/her hands or a mechanical device in order to move your vertebral joints for the express purpose of reducing nerve interference. Risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, less than that associated with a visit to a medical office. Over the counter analgesics, medical care, hospitalization, and surgery all carry their risks. Delay of chiropractic treatment carries consequences: allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic health issues.

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

Print name:_____Signature:_____Today's Date:_____

PAST (AND FUTURE) HEALTH STORY

Name:_____ Date:_____

If your body could improve only one health problem, what would that be?

_____

_____

What other health problem(s) would you like to see your body be able to improve?

_____

_____

How/when did these problems first occur? The earliest occurrence you can remember?

_____

_____

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?_____
*We ask this because you may have tissue damage (ie disc) that affect how quickly **subluxations** come back.*

How often do you feel the pain and how long does it last?_____
*Excess tissue inflammation or pain can cause imbalances in muscles controlling **spinal alignment**.*

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)?_____

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?_____

What is your ideal picture of your future health/function? _____

_____

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.**

I understand that Dr. Fall is a "non-therapeutic" chiropractor and provides "objective straight" chiropractic, offering routine vertebral subluxation location and correction only. We defer to appropriate medical personnel for any and all medical treatment of any symptoms or medical conditions.

We teach vitalistic principles of health and wellness that puts you the practice member firmly in control of your own body. We teach what scientists call "cellular" or "innate" intelligence--the tendency of the body to express self-ordering homeostasis. However, this does not absolve the member of the responsibility to assess their own need for or to concurrently seek out appropriate medical care from their regular primary care medical physician.

PRIVACY ACKNOWLEDGEMENT

I have read and fully understand the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy. I have read and fully understand the above statements.

Print name:_____Signature:_____Today's Date:_____

Name:_____ Date:_____

MUSCULOSKELETAL
☐ 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

Other:_____

GENITOURINARY
☐ 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

Other:_____

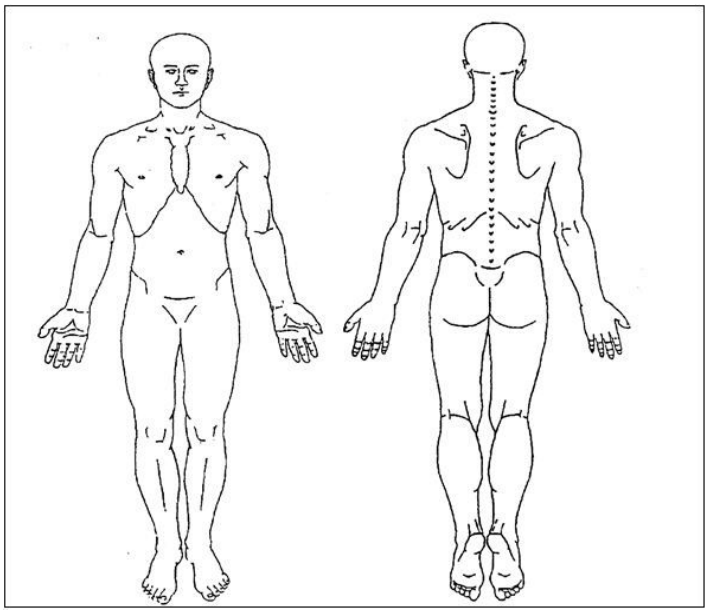
GASTRO-INTESTINAL
☐ Poor appetite
☐ Excessive hunger
☐ Difficulty chewing
☐ Difficult swallowing
☐ Excessive thirst
☐ Nausea
☐ Vomiting food
☐ Vomiting blood
☐ Abdominal pain
☐ Diarrhea
☐ Constipation
☐ Black stool
☐ Bloody stool
☐ Hemorrhoids
☐ Liver trouble
☐ Gallbladder problems
☐ Weight trouble

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 the body chart where you feel pain. **This may indicate tissue damage that our office does NOT treat. However, those conditions can further stress the body which increases prevalence of separate and distinct subluxations that are often silent.**
Mark all affected areas. Include 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