PATIENT REGISTRATION FORM

Name:_____ Date:_____
Address:_____
City/State/Zip Code:_____
Sex: M/F Marital: M/S/D/W DOB:_____ Age:_____
Home Phone #:_____ Work #:_____ Cell #:_____
Email:_____ Occupation:_____
Emergency Contact:_____ Phone Number:_____

Race: (Circle) American Indian Alaska Native Asian Black or African American Decline to State Native Hawaiian Other Pacific Islander White

Ethnicity: (Circle) Decline to state Hispanic or Latino Not Hispanic or Latino

Language Spoken: _____

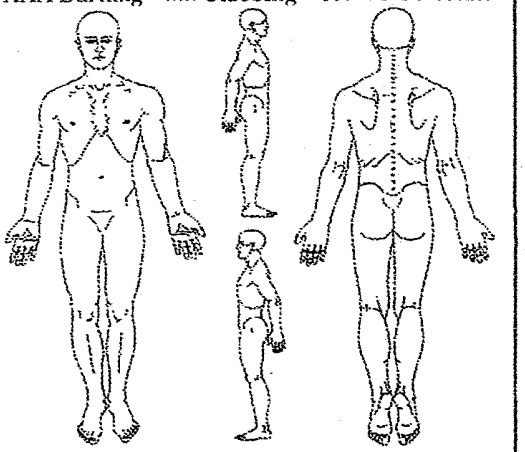
NATURE OF COMPLAINT:

List the major complaints you would like addressed:
Rate the average pain scale (PS) after each item, on a scale Of 0 to 10 with 0=no pain 10= unbearable pain.

1. Main _____ PS____
2._____ PS____
3._____ PS____
4._____ PS____

PLEASE FILL OUT PAIN DRAWING AT RIGHT

Use these symbols on drawing:
++++ Aching = = = Numbness
XXX Burning ///// Stabbing 000 Pins/Needles



HISTORY OF MAIN COMPLAINT:

Do any of these complaints seem related: Y/N
When did this episode begin? _____
Have you had similar symptoms before? Y/N
When? _____
How did it occur? (Circle) Gradually Suddenly
No apparent reason Bending Lifting Fall
Motor Vehicle accident Work related
Has your pain: (circle) Improved Worsened Not changed
Is your pain: (circle) Constant Intermittent Daily Weekly
Does it interfere with (circle) Work Sleep Daily routine Exercise
What activity is limited most by pain? _____

PRIOR TREATMENT OF MAIN COMPLAINT:

Have you seen anyone else for these symptoms: Y/N Who?_____
What did they recommend?_____
Test results for x-ray/Lab/CT/MRI or other:_____
_____
Surgery: Year/ Type:_____ results: Better No Change Worse
Chiropractic: Year_____ results: Better No Change Worse
Physical Therapy: Year_____ results: Better Not Change Worse

FAMILY MEDICAL HISTORY: CIRCLE

Arthritis Diabetes Heart Disease High Blood Pressure Cancer Scoliosis Muscle Disease Rheumatoid Arthritis

Living Parents? Mother Y/N Died at age: ___ of _____

Father Y/N Died at age:____ of _____

YOUR MEDICAL HISTORY: CIRCLE

Anemia Arthritis Asthma Alcoholism Cancer Depression Diverticulitis Diabetes Glaucoma GERD Hepatitis High Blood Pressure Heart Disease Joint Replacement Kidney Disease Lung Disease Lupus Migraine Headaches Prostate Polio Stroke Seizures Scoliosis Sinus trouble Thryroid Disease Ulcers

Women only: Are you pregnant or is there a possibility you may be pregnant? Y/N/ Uncertain

Current Work Status: Circle Regular duty Limited/Light duty Off work date began_____

Lifestyle Habits: Circle Tobacco Y/N If so how much?_____ Have you smoked in the past? Y/N

Alcohol Caffeine beverages

Height:_____

Weight:_____

LIST OF CURRENT MEDICATIONS: Please list amount taken for each.

_____

_____

_____

_____

ALLERGIES TO MEDICATIONS: Y/N IF SO PLEASE LIST.

_____

_____

SURGERIES/HOSPITALIZATIONS/FRACTURES/DISLOCATIONS:

_____**YEAR:**_____

_____**YEAR:**_____

_____**YEAR:**_____

_____**YEAR:**_____

Would you like to view your clinical summaries on line? Y/N

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account on receipt. However, I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient or Guardian's signature:_____ Date:_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

Holly Donaldson, D.C.
335 Davis Street
Traverse City, MI 49686

Consent for Purpose of Treatment, Payment and Health Care Operations

I acknowledge that Dr. Holly Donaldson's Notice of Privacy Practices has been provided to me.
I understand I have a right to review Dr. Holly Donaldson's Notice of Privacy Practices prior to signing this document. Dr. Holly Donaldson's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Holly Donaldson, D.C. The Notice of Privacy Practices for Holly Donaldson, D.C. is also provided on request at the main administrative desk of this practice and on the website of www.traversecitychiropractic.com. This Notice of Privacy Practices also describes my rights and Holly Donaldson's duties with respect to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Holly Donaldson's website, or calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of an appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative Authority