

SnyderChiropracticCare

For better health & wellness

Registration Form

(Please Print)

| | | | |
|--|----------------------------------|---|--|
| Today's Date | | PCP: | |
| Patient Information | | | |
| Patient's last name: | | First: | Middle: |
| | | | |
| | | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. |
| Marital Status: (circle one) Single / Mar / Div / Sep / Wid | | | |
| Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No | If not, what is your legal name? | (Former name): | Birth date: / / |
| | | | Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
| Street address: | | Social security no.: | Home phone no.: () |
| P.O. box: | City: | State | ZIP code: |
| Occupation: | Employer: | Employer phone no.: () | |
| Street address: | | City/State: | ZIP code: |
| Choose clinic because/Referred to clinic by (check one): <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital | | | |
| <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> other | | | |
| Other family members seen here: | | | |
| Insurance Information | | | |
| <i>Please give your current insurance card to the receptionist.</i> | | | |
| Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: () |
| Occupation: | Employer: | Employer address: | Employer phone no.: () |
| Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Is this person covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Please indicate primary insurance <input type="checkbox"/> AETNA <input type="checkbox"/> UNITED HEALTH CARE <input type="checkbox"/> ANTHEM BC/BS <input type="checkbox"/> CIGNA <input type="checkbox"/> BWC <input type="checkbox"/> MEDICARE | | | |
| <input type="checkbox"/> MEDICAID <input type="checkbox"/> OTHER | | | |
| Subscriber's name | | Subscriber's Social Security no.: | Birth date: / / |
| Group no.: | Policy no.: | Co-payment: | |
| Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other | | | |
| Name of Secondary Insurance (if applicable): | | Group no.: | Policy no.: |
| Secondary Subscriber's name: | Subscriber S.S. No.: | Birth date: / / | Co-payment: |
| Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other | | | |
| In Case of Emergency | | | |
| Name of local friend or relative: | Relationship to patient: | Home phone no.: () | Work phone no.: () |

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance and am liable for collections and/or legal fees. I also authorize Snyder Chiropractic Care or insurance company to release any information required to process my claim.

Patient/Guardian signature

Date

SnyderChiropracticCare

For better health & wellness

Patient Health Questionnaire

Patient Name: _____ Date: _____

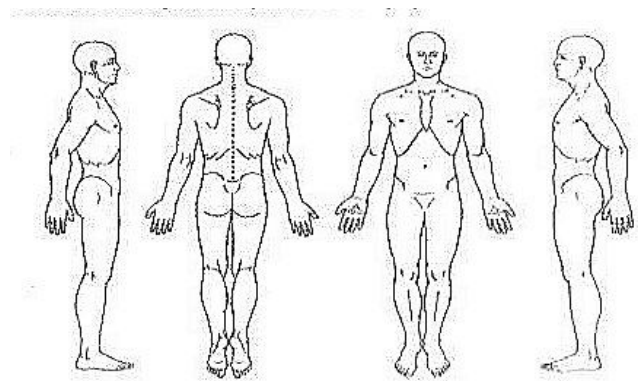
Describe your symptoms: _____

When did your symptoms start? _____

How did your symptoms begin? _____

How often do you experience your symptoms? Indicate where you have pain or other symptoms.

- (1) Constantly (76-100% of the time)
- (2) Frequently (51-75% of the time)
- (3) Occasionally (26-50% of the time)
- (4) Intermittently (0-25% of the time)



What describes the nature of your symptoms?

- (1) Sharp
- (2) Dull ache
- (3) Numb
- (4) Shooting
- (5) Burning
- (6) Tingling

How are your symptoms changing?

- (1) Getting Better
- (2) Not Changing
- (3) Getting Worse

During the past 4 weeks:

None

Unbearable

Indicate the average intensity of your symptoms: (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

How much has pain interfered with your normal work? (including both work outside the home and housework)

- (1) Not at all
- (2) A little bit
- (3) Moderately
- (4) Quite a bit
- (5) Extremely

During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc.)

- (1) None of the time
- (2) A little of the time
- (3) Some of the time
- (4) Most of the time
- (5) All of the time

In general, would you say your overall health right now is...

- (1) Excellent
- (2) Very Good
- (3) Good
- (4) Fair
- (5) Poor

Whom have you seen for your symptoms?

- (1) No one
- (2) Chiropractor
- (3) Medical Doctor
- (4) Physical Therapist
- (5) Other

What treatment did you receive and when? _____

What tests have you had for your symptoms and when were they done?

- (1) X-rays Date: _____ (3) CT Scan Date: _____
- (2) MRI Date: _____ (4) Other Date: _____

Have you had similar symptoms in the past? (1) Yes (2) No

If you have received treatment in the past for the same or similar symptoms, whom did you see?

- (1) This office
- (2) Chiropractor
- (3) Medical Doctor
- (4) Physical Therapist
- (5) Other _____

What is your occupation? (1) Professional/Executive (2) White collar/secretarial (3) Tradesperson (4) Laborer (5) Homemaker (6) FT Student (7) Retired (8) Other

If you are not retired, a homemaker or a student, what is your current work status?

- (1) Full-time
- (2) Part-time
- (3) Self-employed
- (4) Unemployed
- (5) Off-work
- (6) Other

Patient Signature: _____ **Date:** _____

Patient Health Questionnaire (continued)

Patient Name: _____ Date: _____

What type of regular exercise do you do? (1) None (2) Light (3) Moderate (4) Strenuous

What is your height and weight? Height: _____ feet _____ inches Weight _____ pounds

For each of the conditions listed below, place a check in the **Past** column if you have had the condition in the past. If you presently have a condition listed below, place a check in the **Present** column.

| Past | Present | | Past | Present | | Past | Present | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------------|------------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Mid Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Smoke/Use Tobacco |
| <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | Drug/Alcohol Dependence |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow/Upper Arm Pain | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist Pain | <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection | <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain | <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination | <input type="checkbox"/> | <input type="checkbox"/> | Systemic Lupus |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip/Upper Leg Pain | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems | <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/Eczema/Rash |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee/Lower Leg Pain | | | | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle/Foot Pain | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight Gain/Loss | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite | Females Only | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain | <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills |
| <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer | <input type="checkbox"/> | <input type="checkbox"/> | Hormonal Replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Swelling/Stiffness | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Liver/Gall Bladder Disorder | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis | | | | Other Health Problems/Issues | | |
| <input type="checkbox"/> | <input type="checkbox"/> | General Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular Incoordination | <input type="checkbox"/> | <input type="checkbox"/> | Tumor | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis | <input type="checkbox"/> | <input type="checkbox"/> | |

Indicate if an immediate family member has had any of the following:

Rheumatoid Arthritis Heart Problems Diabetes Cancer Lupus Other _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

List all the surgical procedures you have had and times you have been hospitalized:

Patient Signature: _____ **Date:** _____

Doctor's Additional Comments: _____

Doctor's Signature: _____ Date: _____

Consent for Chiropractic Treatment

State law requires us to obtain your consent prior to your chiropractic treatment. What you are being asked to sign is simply a confirmation that we have discussed your contemplated treatment and that we have given you sufficient information upon which to make a decision whether to have the treatment and any choice as to the type of treatment of your own free will. We will discuss with you the common problems or undesired results that sometimes occur. We wish to inform you, not alarm you. If you wish, however, we can go into more elaborate details of more unlikely problems. If you do not, that is also your privilege. Please read the form carefully. Ask about anything that you do not understand. We will be pleased to explain it.

I hereby authorize and direct **Dr. Patrick Snyder**, with the associate(s) or assistant(s) of his choice to perform the following chiropractic procedures on

_____, my _____ as we have agreed upon.
Patient Name Relationship, if minor

- The nature and purpose of the treatment to be performed by the physician are: Chiropractic Adjustment/Therapy.
- These treatments are expected to accomplish: increase range of motion and decrease muscle spasms.
- The reasonably known risks of the treatments are: initial stiffness and discomfort.
- Details of this treatment and alternative methods of treatment have been explained to me. I have been advised that, although good results are expected, each situation/person reacts differently to the treatment; therefore, the outcome of the treatment has no guarantee as expressed or implied.
- The doctor has explained to me the most likely complications that may occur from this treatment and I understand them. I have also been told the less likely complications, even if rare, that could occur.
- I hereby authorize Dr. Patrick Snyder and his associates/assistants to provide additional procedure(s) as they deem reasonable and necessary including, but not limited to, x-rays/therapy.
- I hereby affirm and state that I have read and understood this consent and that all blanks were filled in prior to my signature.

Date _____ Signature _____

The patient is unable to execute this consent for the following reason(s): _____

Witness _____

I certify that I have personally reviewed all the blanks on this form and explained them to the patient or his/her representative before requesting the patient or his/her representative to sign this form.

Physician Signature: _____

Memo to our Patients Regarding HIPAA

As you may know, a new law has been passed that relates to how we may use your personal health information. We have always been in the forefront regarding patient confidentiality; and, for years, have been very careful with how we share your information with other people and have tried to protect your privacy. So, you will probably not notice that this law will affect our interaction that much.

We are required by law to have to sign a statement that you have received a copy of your rights under the law. This is called the "Notice of Privacy Practices".

Please sign and date this page indicating that you have been allowed to read the "Notice of Privacy Practices" and were offered a paper copy if so desired.

Print Patient Name _____

Signature of Patient or Guardian _____

Date _____