BALTIMORE CHIROPRACTIC CLINIC

Patient Registration and History Form

First Name: _____Middle: _____Last _____

Address _____

City_____ State_____ Zip Code_____

Country: US__ or Other (name) _____

What is Your Age? _____Height? _____Weight? _____

Social Security _____Birthdate _____Sex: M___F___

Marital Status: Married __ Single __ Divorced __ Separated __Widowed__ Spouses Name_____

Home Phone_____ Work Phone_____

Cell Phone_____

Email_____

Preferred Communication: Home___ Cell___ Work___ Email___

Place of Employment_____ Occupation_____

Emp. Address_____City_____State____Phone_____

Smoking Status: Current Every Day___ Current Some Days___ Former Smoker___ Never Smoked___

If so, what type tobacco and how much? _____ If quit, when? _____

Do you drink Alcohol? Yes__ No__ If so, how much and how frequent? _____

Race: American In/Alaska Native__ Asian__ Black/African Am__

American__ White__ Patient Declined__

Ethnicity: Hispanic/Latino__ Not Hispanic/Latino__ Pt Declined__

Preferred Language _____ Shoe Size_____

Please List all Medications you are currently taking: (If you have a list, I will copy)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any Allergies you have: (Medication, Food, Environmental)

_____ _____ _____

_____ _____ _____

Have you ever been treated by a Chiropractor before? Yes__ No__

Cause of injury is (Please Circle): Work, Sports, Auto, Unknown, Trauma or Chronic

When did this condition begin? _____/_____/_____

Are you missing work because of these symptoms? Yes__ No__

Is this condition getting Worse? Yes__ No__ Constant__ Comes and goes__

Explain what happened: _____

_____

_____

_____

_____

Please describe the pain and its location: _____

_____

_____

_____

_____

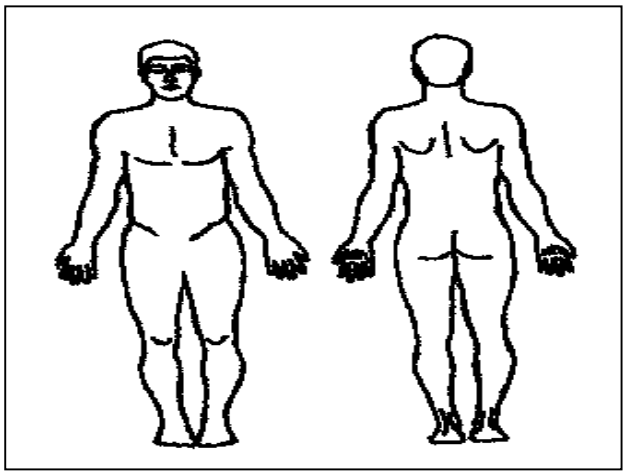
Instructions: For #1 and #2, please circle the number that best describes the question being asked. If you have more than one complaint, please write each complaint above the corresponding number you are circling. After answering the 2 questions, mark using the symbol corresponding to your complaint on the body picture where you have pain and/or symptoms.

1. I would rate the intensity of my symptoms as:

0	1	2	3	4	5	6	7	8	9	10
Very Mild		Mild			Moderate			Severe		

2. I feel the symptoms:

0	1	2	3	4	5	6	7	8	9	10
Never		Seldom			On & Off			Constant		



. xx Sharp Pain, // Dull Pain, >> Radiating Pain

oo Numbness/Tingling, BB Burning

Is this condition interfering with your (Please Circle): Work, sleep, sitting, standing, walking, and/or daily routine? If yes, please explain: _____

_____

_____

Have you had similar conditions in the past? Yes__ No__ If so, explain: _____

_____

_____

Have you been treated by a Medical Physician for this condition: Yes__ No__

If so, where: _____

PAST MEDICAL HISTORY

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience.

O Alcohol Dependence ___/___/____	**O** Allergies ___/___/____	**O** Anemia ___/___/____
O Angina ___/___/____	**O** Anxiety ___/___/____	O Appendicitis ___/___/____
O Arthritis ___/___/____	**O** Artificial Joints ___/___/____	**O** Asthma ___/___/____
O Blood Clots ___/___/____	**O** Broken Bones ___/___/____	**O** Cancer ___/___/____
O Carpal Tunnel Syndrome ___/___/___	**O** Chronic Blood Thinner Use ___/___/___	**O** Chronic Fatigue Syndrome ___/___/___
O Chronic Sinusitis ___/___/___	**O** Circulatory Disease ___/___/____	**O** Colitis ___/___/____
O Congestive Heart Failure ___/___/____	**O** COPD ___/___/____	**O** Crohn's Disease ___/___/____

O Depression ___/___/____
O Drug Dependence ___/___/____
O Difficulty Breathing ___/___/____
O Fibromyalgia ___/___/____
O Glaucoma ___/___/____
O Headaches ___/___/____
O Heart Disease ___/___/____
O High Cholesterol ___/___/____
O Insomnia ___/___/____
O Kidney Disease ___/___/____
O Low Blood Pressure ___/___/____
O Nerve Pain/Neuritis ___/___/____
O Orthotics ___/___/____
O Pacemaker ___/___/____
O Sciatica ___/___/____
O Sleep Apnea ___/___/____
O Thyroid Disease ___/___/____
O Vertigo ___/___/_____

O Diabetes Type I ___/___/____
O Disc Degeneration ___/___/____
O Emphysema ___/___/____
O Gallbladder Stones ___/___/____
O Goiter ___/___/____
O Heel Lifts ___/___/____
O Herniated Disc ___/___/____
O Irregular Heart Rhythm ___/___/____
O Irritable Bowel Syndrome ___/___/____
O Liver Disease ___/___/____
O Migraines ___/___/____
O Numbness/Tingling ___/___/____
O Osteoarthritis ___/___/____
O Palpitations ___/___/____
O Seizures/Epilepsy ___/___/____
O Stomach Ulcer ___/___/____
O Tinnitus ___/___/____

O Diabetes Type II ___/___/____
O Duodenal Ulcer ___/___/____
O Esophageal Reflux ___/___/____
O Gallbladder Disease ___/___/____
O Gout___/___/____
O Heart Attack ___/___/____
O High Blood Pressure ___/___/____
O Hyperthyroidism ___/___/____
O Kidney Stones ___/___/____
O Low Back Pain ___/___/____
O Neck Pain ___/___/____
O Obesity ___/___/____
O Osteoporosis ___/___/____
O Rheumatoid Arthritis ___/___/____
O Shingles ___/___/____
O Stroke (CVA) ___/___/____
O Tuberculosis ___/___/____

Please list any other serious medical conditions(s)/surgeries/treatments or serious accidents with dates, and give explanation of all mentioned history._____

_____

_____

_____

Contact Permission

May we leave messages at home with other residents? Yes___ No___

May we leave personal health information on your answering machine/voicemail? Yes* ___ No___

May we contact you via e-mail or cellular telephone? Yes** ___ No___

May we contact you via text message? Yes**___ No ___

*Appointment reminders will be left on voicemail.

**We cannot ensure the confidentiality of information shared by these means.

Who may we contact in case of Emergency? Name _____

Relationship_____Phone#1_____Phone#2_____

Please list below all individuals with whom we may talk to about your medical concerns:

Please Note: We will not release any personal health information to anyone unless they are listed below

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

If you would like to be able to access your records in the future via the internet, please fill out a user name and password that we can enter into our computer. Then pick one security question and answer it (in the event that you lose your user name and password).

User Name_____

Password_____

Security Question: Mother's Maiden Name_____ Pet's Name_____

City Where I was Married_____ City Where I went to School_____

Baltimore Chiropractic Clinic Phone: 740-862-3154
117 East Mulberry Street Fax: 740-862-3186
Baltimore, Ohio 43105

We invite you to discuss frankly with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Our office policy requires payment in full for all services rendered at the time of visits, unless other arrangements have been made. If the account is not paid within 90 days of the date of service, and no financial arrangement has been made, you will be responsible for any expenses incurred in collecting your account. We reserve the right to bill for missed appointments. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I hereby authorize payment of benefits directly to the provider of benefits due me for services rendered. If my current policy prohibits direct payment to doctor, then I hereby also authorize the payment of benefits be made out to me and then mailed to this office. This applies also in cases involving litigation. I further authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case. I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status.

Electronic Health Records. I understand that the Physician Office may collaborate with other health care providers to coordinate, manage and provide health care to me and I consent to the Physician Office's sharing my health information and records electronically for the purposes of treatment, payment or operations, including improving the overall quality of health care services provided to me (e.g. avoiding unnecessary or duplicate testing, etc.). I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. The electronic health records HER will be accessible by credentialed physicians/practitioners as well as other individuals approved to access the EHT for purposes related to treatment, payment, health care operations and/or other purposes permitted by federal and state laws, including the Health Insurance Portability and Accountability Act ("HIPPA"). The physician office has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of my medical information as required by HIPPA.

Use and disclosure of Information. In addition to the above consent to use and share my health information I agree that the Physician Office may use and disclose my health information for a range of purposes including: Treatment, eligibility verification, and/or payment to private and public payers or their agents including insurance companies, managed care organizations, my employer (if I am injured at work), state and federal government programs, Workers' Compensation programs, quality of care assessment and improvement activities, conducting or arranging for medical review, audit services, ensuing compliance with legal, regulatory and accreditation requirements and public health and health oversight services.

Request for Information from Others. I consent to the Physician Office's request of my health information from other providers of care to me, receipt of and release of health information, whether written, verbal, or electronic, for the uses described above as well as the Physician Office's participation in any health information exchange described in the Physician Office's Notice of Privacy Practices (NPP). Please refer to the NPP for additional, detailed information regarding the uses and disclosures of protected health information.

I understand that the Physician Office does not accept responsibility for any lost, stolen or damaged personal items while I am at the Physician Office.

If the patient is under age 18, the parent or guardian must sign below to give consent for examination/treatment. If the minor does not reside with both parents, and there is a dispute over which parent is responsible for any bills, we will ultimately rely upon the parent/guardian who brought the child to the office for financial responsibility.

I acknowledge that I have received or been offered a copy of Physician Office's Notice of Privacy Practices which provides information on how the Physician Office may use or disclose PHI for purposes of treatment, payment, or health care operations. Please Initial_____

Signature of Responsible Person: _____Date: __/___/_____

Printed Name of Responsible Person: _____