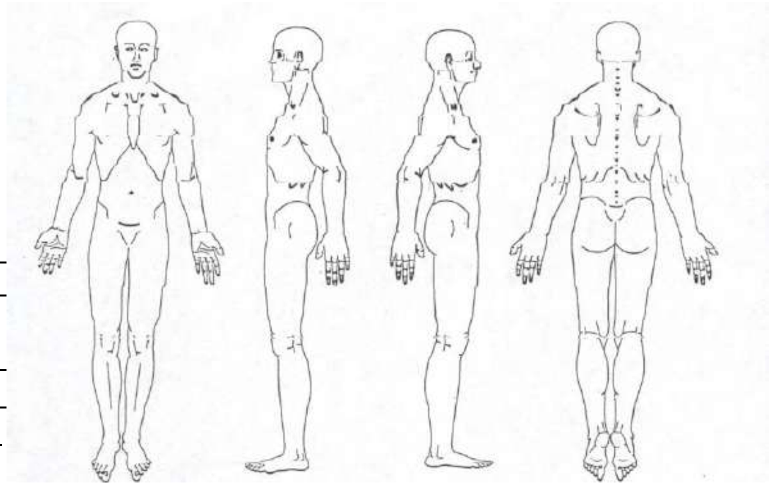
REGISTRATION

Date ____________ Home Phone ____________ Work Phone ____________ Cell Phone ____________
Patient Last Name ____________ First Name ____________ Initial ____ Email ____________
Street Address ____________
City ____________ State ____________ Zip ____________
Sex □ M □ F Age ________ Birth date ________ □ Single □ Married □ Widowed □ Separated □ Divorced
Social Security # ____________
Insured Name ____________ how and where did you learn about this clinic? ____________
Last Name First Name Initial
Relationship to Insured □ Self □ Spouse □ Child □ Other
Condition/ Illness Related To □ Illness □ Employment □ Auto □ Other

EMPLOYER	Company Name ____________ Occupation ____________ Address ____________ Phone ____________ □ Full-time □ Part-time City ____________ State ________ Zip ________ Years Employed ____________
SPOUSE (PARENT)	Name ____________ Birth date ____________ SSN: ____________ Last Name First Name Initial Employer Name ____________ Years Employed ____________ Address ____________ Phone ____________ Occupation ____________ City ____________ State ________ Zip ________ □ Full-time □ Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name ____________ Policy/Group #: ____________ Effective Date: ____________ Name of Insured: ____________ ID #: ____________
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name ____________ Policy/Group #: ____________ Effective Date: ____________ Name of Insured: ____________ ID #: ____________
MEDICAL AND LEGAL INFORMATION	Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? □ Yes □ No Your Initials: ________ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant □ Yes □ No Pacemaker □ Yes □ No Family Physician ____________ Person to contact in an emergency ____________ Phone ____________ Relationship ____________ I have been given a copy of the HIPPA Notice to keep ____________
PATIENT AGREEMENT	**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Schwietert Chiropractic Clinic, P.C. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. **I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.** *I hereby authorize the doctor to release all medical information necessary to process this claim.* I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. ____________________ ____________ Signature of Insured / Guardian Date

SCHWIETERT CHIROPRACTIC CLINIC, P.C.

Patient Name (please print)____Date of Birth___________________



Indicate on this picture where you have pain or other symptoms.

(Please circle all areas of involvement)

Present Complaint/Reason for Seeking Care in this Office?
Major:____
Pain or Problem started on?__________________________
How did complaint occur?
____
____
____

How often do you experience your symptoms?

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

What describes the nature of your symptoms?

❒ Sharp ❒ Numb
❒ Shooting ❒ Burning
❒ Dull Ache ❒ Tingling

How are your symptoms changing?
❒ Getting Better
❒ Not Changing
❒ Getting Worse

What is the intensity of your symptoms?

	0	1	2	3	4	5	6	7	8	9	10
Worst	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒
Best	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒
Today	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒

What activities aggravate your condition/pain?____
What activities lessen your condition/pain?____
Is this condition worse during certain times of the day?____
Is this condition interfering with: Work?____________ Sleep?_____________ Routine?_____________ Other?_______________

Have you received treatments in the past for this similar symptom or complaint? Yes__________ No__________

Who/Where?____

- ∆ This office
- ∆ Other Chiropractor
- ∆ Medical Doctor
- ∆ Physical Therapist

What Tests did you receive for your symptoms?
(Please Circle)
X-Rays
CT Scan
MRI Scan

** Are your present symptoms or condition related to or the result of an auto accident, work related injury or other personal injury that someone else might be legally liable for? Yes _____ No _____ Your Initials __________

Patient or Guardian Signature____Date ________________________

---OFFICE USE---

Height______________ Weight______________Blood Pressure: Left____________________________ Right____________________________

SCHWIETERT CHIROPRACTIC CLINIC, P.C.

Patient Name (please print)____ Date of Birth____________

Past	Present
❒	❒ Headache
❒	❒ Neck Pain
❒	❒ Upper Back Pain
❒	❒ Mid Back Pain
❒	❒ Low Back Pain
❒	❒ Shoulder Pain
❒	❒ Elbow / Upper Arm Pain
❒	❒ Wrist Pain
❒	❒ Hand Pain
❒	❒ Hip / Upper Leg Pain
❒	❒ Knee / Lower Leg Pain
❒	❒ Ankle / Foot Pain
❒	❒ Jaw Pain
❒	❒ Scoliosis
❒	❒ Joint Swelling / Stiffness
❒	❒ Arthritis
❒	❒ Rheumatoid Arthritis
❒	❒ General Fatigue
❒	❒ Muscular Incoordination
❒	❒ Fainting
❒	❒ Visual Disturbances
❒	❒ Convulsions
❒	❒ Dizziness
❒	❒ Tinnitus (ear noises)
❒	❒ Cancer
❒	❒ Tumor

Past	Present
❒	❒ High Blood Pressure
❒	❒ Heart Attack
❒	❒ Chest Pains
❒	❒ Stroke
❒	❒ Rapid Heart Beat
❒	❒ Angina
❒	❒ Aortic Aneurysm
❒	❒ Blood Disorder
❒	❒ Kidney Stones
❒	❒ Kidney Disorders
❒	❒ Bladder Infection
❒	❒ Painful Urination
❒	❒ Loss of Bladder Control
❒	❒ Prostate Problems
❒	❒ Abnormal Weight Gain / Loss
❒	❒ Anorexia
❒	❒ Loss of Appetite
❒	❒ Abdominal Pain
❒	❒ Difficulty Swallowing
❒	❒ Constipation
❒	❒ Heartburn Indigestion
❒	❒ Ulcer
❒	❒ Colitis
❒	❒ Irritable Colon
❒	❒ Hepatitis
❒	❒ Liver / Gall Bladder Disorder

Past	Present
❒	❒ Emphysema
❒	❒ Asthma
❒	❒ Chronic Cough
❒	❒ Chronic Sinusitis
❒	❒ Diabetes
❒	❒ Excessive Thirst
❒	❒ Frequent Urination
❒	❒ Systemic Lupus
❒	❒ Epilepsy

Dermatitis / Eczema / Rash

Past	Present
❒	❒ Depression
❒	❒ Drug / Alcohol Dependence
❒	❒ HIV/AIDS

Females Only:

First Day of last menstrual cycle ____________________

Past	Present
❒	❒ Irregular Menstrual Flow
❒	❒ Profuse Menstrual Flow
❒	❒ Breast Soreness / Lumps
❒	❒ Endometriosis
❒	❒ PMS
❒	❒ Birth Control Pills
❒	❒ Hormonal Imbalance
❒	❒ Pregnancy

❒ ❒ TOBACCO USE: Non-Smoker Sometimes Smoker Everyday Smoker Smokeless Tobacco Per Day Use________
FORMER SMOKER: (choose one) < 1 year 1-2 years 3-4 years 5+ years 10+ years

Indicate if any family member has ever had any of the following:

❒ Chronic Back problems	❒ Rheumatoid Arthritis	❒ High Blood Pressure	❒ Cancer	❒ Lupus
❒ Chronic Headaches	❒ Lung Problems	❒ Heart problems	❒ Diabetes	❒ Other

Do you have a permanent disability rating? ❒ Yes ❒ No Rating %__________ Date rating received__________________

Describe your disability____

List all prescription and over- the- counter medications you are taking__________________________________

____

List all surgical procedures you have had and times you have been hospitalized______________________________

____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to do whatever is necessary in accordance with this state's statues, to provide me with chiropractic care.

Patient or Guardian Signature____**Date**________________

SCHWIETERT CHIROPRACTIC CLINIC
INFORMED CONSENT TO TREAT

PATIENT NAME: ____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:
spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, ultrasound, hot/cold therapy and EMS. Physical therapy, massage and exercises may also be used.

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation, extra spinal manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:
• Self-administered, over-the-counter analgesics and rest • Hospitalization • Surgery
• Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. James Schwietert and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Signature: ____ **Date:** ____________________
(Patient, Parent or Guardian, if minor)