CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co: _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

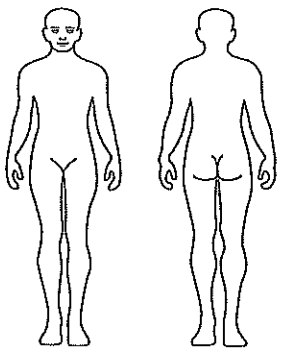
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

_____
_____
_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

PATIENT NAME _____ DATE_____

I. INFORMED CONSENT TO CHIROPRACTIC TREATMENT

1. I hereby request consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible :_____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.
2. I further understand that such chiropractic services may be performed by the Physician of Chiropractic, Dr. David L. Bradham, D.C. and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. David L. Bradham and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.
3. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedures which the physician feels are in best interests at the time, based upon the facts then known.

II. ACKNOWLEDGEMENT OF INFORMED CONSENT TO ACUPUNCTURE TREATMENT

4. I hereby acknowledge and affirm my decision to engage in Acupuncture Treatment by Dr. David L. Bradham, D.C. and Bradham Chiropractic Clinic, P.A.
5. I hereby acknowledge that Acupuncture is done in order to maintain or restore my health by methodology that does not use medicine or surgery by rather relies upon Oriental principles of healing and balancing Ying/Yang.
6. I recognize and acknowledge that the outcome of my treatment and whether or not any benefits result from this treatment are dictated by the individual patient, time of day, environment, underlying healthcare concerns and causes of the same, as well as physical and spinal condition of each patient.
7. I acknowledge that Dr. David L. Bradham, D.C. and Bradham Chiropractic Clinic, P.A. performed an acupuncture (EMI) exam for the express purpose of deciding whether I may have Meridian Vertebral Imbalance. I have been informed that when these syndromes or complexes are present, Acupuncture and Ancillary Procedures may improve such conditions.
8. I further understand and acknowledge that neither Dr. David L. Bradham, D. C., nor any member of the staff of Bradham Chiropractic Clinic, P.A. can guarantee any specific results by and through Acupuncture. I acknowledge that Dr. Bradham explained to me that there are numerous reasons why Acupuncture may produce no or less than expected results for me based upon a variety of reasons such as an individual's nervous system, body balance, etc., and other individualized factors.
9. I specifically acknowledge that I have been fully informed by Dr. David L. Bradham, D. C. and Bradham Chiropractic Clinic, P.A. that Acupuncture may not prove beneficial to me. I acknowledge further specifically that I have been informed that underlying physical defects, deformities or pathologies I have, may make me more susceptible to injury and it is my responsibility as a patient to make known or to learn through healthcare procedures all that I can regarding my physical conditions, any latent pathological defects I may have, any illnesses or deformities which would others not come to the attention of Dr. David L. Bradham, D.C. and Bradham Chiropractic Clinic, P.A. and the make my Dr. David L. Bradham, D.C., and Bradham Chiropractic Clinic, P.A. aware of the same.
10. I acknowledge that with each individual, it is not possible for Dr. David L. Bradham, D.C., or any member of Bradham Chiropractic Clinic, P.A. to specify the time schedule or when I should be aware of noticeable benefits of the procedures, understanding that positive results may be gradual. I further acknowledge that results may be less than expected and that my body may not respond to or my health may not improve with Acupuncture.

Initial _____

III. FURTHER ACKNOWLEDGEMENT OF CONSENT TO TREATMENT AND DISPUTE RESOLUTION

11. I have read, or have read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.
12. I understand and have been advised that spinal alignment allows for nerve transmission to be improved as well as providing an opportunity for better recuperation process to be implemented within the body.
13. I acknowledge that I have been given the opportunity to ask questions and seek a second opinion and to voice any concerns I may have and I am satisfied with the advice I have been given and hereby give Dr. David L. Bradham, D.C. and Bradham Chiropractic Clinic, P.A. I consent for Acupuncture treatment and acknowledge that I have been fully informed of the risks and benefits of the same.
14. If a dispute, claim or controversy arises out of or relates to this procedure or any other performed by Dr. David L. Bradham, D.C., or Bradham Chiropractic Clinic, P.A. and if the dispute cannot be settled through negotiations, I agree first to try in good faith to settle this dispute by mediation in North Carolina as governed by the North Carolina General Statutes and will do so prior to resulting in litigation. I agree the Courts of North Carolina in Harnett County shall have exclusion jurisdiction for purposes of litigating any dispute arising out of or relating this Agreement. Demand for mediation may be made no later than the time that such action would be permitted under applicable North Carolina Statute of Limitations. Each party shall pay all of their mediation expenses including but not limited to the mediator's fee, attorney fees and expert fees.
15. If either party requests mediation, said request shall be made in writing and mailed certified to the opposing party. The part requesting mediation shall provide to the opposing party the names of three court-certified mediators simultaneously with the request for mediation. Thereafter, the opposing party shall select one of the three proposed mediators; however, if the opposing party shall select one of the three proposed mediators, that party shall submit in writing the three court-certified mediators of his or her choosing within ten days to the party initialing mediation. The parties shall then select one mediator from his or her respective list and each party shall employee said mediator to confer and together select for the parties a third court certified mediator outside of those previously proposed. Mediation shall then proceed and the parties shall adhere to the instructions of the mediator as to the mediation process.
16. I hereby agree to reimburse Dr. David L. Bradham, D.C. and Bradham Chiropractic Clinic, P.A. for their attorney's fees and costs incurred in any legal action I may bring against them if it is deemed they are the prevailing party.
17. If any provision, section, subsection clause or phrase of this release form is found to be unenforceable or invalid, that portion shall be served from this contract. Remainder of the contract shall then be construed as though the unenforceable portion had never been contained in the document.

I HAVE READ THIS AGREEMENT, I UNDERSTAND AND AGREE TO BE BOUND BY ITS TERMS, AND HAVE EXECUTED IT FREELY AND VOLUNTARILY. I HEREBY DECLARE THAT I AM OF LEGAL AGE (AND HAVE PROVIDED VALID PROOF OF MY AGE) AND I AM COMPETENT TO SIGN THIS AGREEMENT OR, IF NOT, THAT MY PARENT OR LEGAL GUARDIAN SHALL SIGN ON MY BEHALF, AND THAT MY PARENT OR LEGAL GUARDIAN IS IN COMPLETE UNDERSTANDING AND CONCURRENCE WITH THIS AGREEMENT.

Patient's Full Name (printed) _____ **Date of Birth** _____

Address _____ **Telephone** _____

Signature _____ **Date** _____

Signature of Parent or Guardian if the Patient is a Minor, and by their signature they, on my behalf, release all claims that both they and I have.

Signature_____ **Date**_____