MOSENG CHIROPRACTIC

Patient Registration

How did you hear about our office? _____

Last Name _____ First Name _____ Middle Initial _____

Birth Date _____ Age _____ Gender M ___ F ___

Single ___ Married ___ Divorced ___ Separated ___ Widowed ___

Spouse's Name _____

Email Address (optional) _____

Mailing Address

Street or P.O. Box _____

City _____ State _____ Zip _____

Home Phone (_____)_____ **Cell Phone** (_____)_____ **Wireless Carrier** _____

Employer Name _____ Full-time ___ Part-time ___

Street or P.O. Box _____

City _____ State _____ Zip _____ Phone (_____)_____

Your Occupation _____

Responsible Party's Name _____ Relationship _____

Street or P.O. Box _____

City _____ State _____ Zip _____ Phone (_____)_____

Relative NOT Living with You _____ Relationship _____

Street or P.O. Box _____

City _____ State _____ Zip _____ Phone (_____)_____

Primary Complaint _____

_____

Condition Caused by Auto Accident ___ Chronic Condition ___
Job Related Accident ___ Illness ___
Other (describe) _____

If due to an accident, in which state did the accident occur? _____

YOUR INSURANCE Insurance Company Name _____

Street or P.O. Box _____

City _____ State _____ Zip _____ Phone (_____)_____

Claim Number _____ **Group Number** _____ **ID or Policy Number** _____

Insured's Information

Last Name _____ First Name _____ Middle Initial _____

Birth Date _____ Gender M ___ F ___ Relationship to Patient _____

Street or P.O. Box _____

City _____ State _____ Zip _____ Phone (_____)_____

Employer's Name _____

Street or P.O. Box _____

City _____ State _____ Zip _____ Phone (_____)_____

OTHER INSURANCE Insurance Company Name _____

Street or P.O. Box _____

City _____ State _____ Zip _____ Phone (_____)_____

Claim Number _____ **Group Number** _____ **ID or Policy Number** _____

Insured's Information

Last Name _____ First Name _____ Middle Initial _____

Birth Date _____ Gender M ___ F ___ Relationship to Patient _____

Street or P.O. Box _____

City _____ State _____ Zip _____ Phone (_____)_____

Employer's Name _____

Street or P.O. Box _____

City _____ State _____ Zip _____ Phone (_____)_____

ATTORNEY Attorney Name _____

Firm Name _____

Street or P.O. Box _____

City _____ State _____ Zip _____ Phone (_____)_____

I promise to pay Moseng Chiropractic all balances due for services rendered. I understand that any insurance contracts are between me and my insurance company, and I am responsible for any amount not paid by my insurance. I further agree to pay a service charge of one and one-half percent (1 1/2%) per month on any unpaid balance after 30 days from treatment date and all collection costs associated with such balances, including reasonable attorney's fees.

Patient/Guarantor Signature _____ **Date** _____

CHIROPRACTIC HEALTH QUESTIONNAIRE

Date _____

Patient Name _____ Birthdate _____

Reason for Visit _____

Have you been treated for this problem before? ☐ No ☐ Yes

If yes, by ☐ Physician ☐ Doctor of Chiropractic ☐ Physical Therapist ☐ Osteopath ☐ Other _____

What did they do and/or recommend? _____

When did your symptoms appear? _____

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

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 ☐ Walking ☐ Bending ☐ Lying Down

☐ Other _____

Describe activities performed in your occupation _____

Have you ever had chiropractic care for other problems? ☐ No ☐ Yes When? _____

Do you take ☐ Muscle Relaxers ☐ Pain Killers ☐ Insulin ☐ Birth Control Pills ☐ Over-the-Counter Medications

☐ Other Prescription Drugs *Please list all medications at the bottom of the page*

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 _____

Sleep _____ hrs/night Do you sleep on your ☐ Back ☐ Side ☐ Stomach Non-job exercise _____ hrs/night

Age of mattress _____ years or waterbed _____years Is your bed comfortable ☐ No ☐ Yes

What type of pillow do you use? ☐ Thick ☐ Medium ☐ Thin ☐ None ☐ Support

Do you wear ☐ Heel lifts ☐ Shoe lifts ☐ Arch supports ☐ Orthotics (describe) _____

CONDITIONS — Check conditions that you have or have had in the past

☐ AIDS	☐ Diabetes	☐ Liver Disease	☐ Rheumatic Fever
☐ Alcoholism	☐ Emphysema	☐ Measles	☐ Scarlet Fever
☐ Anemia	☐ Epilepsy	☐ Migraine headaches	☐ Stroke
☐ Anorexia	☐ Fractures	☐ Miscarriage	☐ Suicide attempt
☐ Appendicitis	☐ Glaucoma	☐ Mononucleosis	☐ Thyroid problem
☐ Arthritis	☐ Goiter	☐ Multiple sclerosis	☐ Tonsillitis
☐ Asthma	☐ Gonorrhea	☐ Mumps	☐ Tuberculosis
☐ Bleeding disorders	☐ Gout	☐ Osteoporosis	☐ Tumor, growths
☐ Breast lump	☐ Heart disease	☐ Pacemaker	☐ Typhoid Fever
☐ Bronchitis	☐ Hepatitis	☐ Pneumonia	☐ Ulcers
☐ Bulimia	☐ Hernia	☐ Polio	☐ Vaginal infections
☐ Cancer	☐ Herpes	☐ Prostate problem	☐ Venereal disease
☐ Cataracts	☐ High Cholesterol	☐ Prosthesis	☐ Whopping cough
☐ Chemical dependency	☐ HIV positive	☐ Psychiatric care	☐ Other _____
☐ Chicken pox	☐ Kidney disease	☐ Rheumatoid arthritis	_____

MEDICATIONS — List medications you are currently taking

_____

_____

_____

Allergies _____

Pharmacy Name _____ Phone_____

VITAMINS / MINERALS / HERBS

_____

_____

_____

_____

_____

GENERAL SYMPTOMS — Check symptoms that you have or have had in the past year

GENERAL
- ☐ Bruise easily
- ☐ Chills
- ☐ Dental problems
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Tiredness
- ☐ Weight gain

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTENSTINAL
- ☐ Appetite, poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hayfever
- ☐ Hoarseness
- ☐ Hard of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in the ears
- ☐ Sinus problem
- ☐ Vision—flashes
- ☐ Vision—halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal pap test
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Last period _____
Last pap test _____
Have you had a mammogram ☐Y ☐N
Pregnant? ☐ Y ☐ N
No. of children _____

EXTREMETIES — Check symptoms that you have or have had in the past year

NECK
- ☐ Pain in neck
- ☐ Neck stiffness
- ☐ Neck weakness
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck

Grinding/popping sounds in neck

SHOULDERS	Right	Left
☐ Pain in shoulder joint	☐ R	☐ L
☐ Pain across shoulders		
☐ Can't raise arm	☐ R	☐ L
☐ Above shoulder level	☐ R	☐ L
☐ Over head	☐ R	☐ L
☐ Tension in shoulders		
☐ Pinched nerve in shoulder	☐ R	☐ L

MID-BACK
- ☐ Mid-back pain
- ☐ Mid-back stiffness
- ☐ Pain between shoulder blades
- ☐ Pain from front to back
- ☐ Muscle spasms in mid-back

ARMS & HANDS	Right	Left
☐ Pain in upper arm	☐ R	☐ L
☐ Pain in elbow	☐ R	☐ L
☐ Pain in forearm	☐ R	☐ L
☐ Pain in hand	☐ R	☐ L
☐ Pain in fingers	☐ R	☐ L
☐ Pins/needles - arm	☐ R	☐ L
☐ Pins/needles - fingers	☐ R	☐ L
☐ Numbness in arm	☐ R	☐ L
☐ Numbness in fingers	☐ R	☐ L
☐ Weakness of arm	☐ R	☐ L
☐ Weakness of hand	☐ R	☐ L
☐ Hands cold	☐ R	☐ L

LOW BACK
- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Low back weakness
- ☐ Pinched nerve in low back
- ☐ Low back feels out of place
- ☐ Muscle spasms in low back

HIPS, LEGS, FEET	Right	Left
☐ Pain in buttocks	☐ R	☐ L
☐ Pain in hip joint	☐ R	☐ L
☐ Pain down leg	☐ R	☐ L
☐ Pain in knee	☐ R	☐ L
☐ Pain in ankle	☐ R	☐ L
☐ Pain in foot	☐ R	☐ L
☐ Leg weakness	☐ R	☐ L
☐ Knee weakness	☐ R	☐ L
☐ Leg Cramps	☐ R	☐ L

OTHER SYMPTOMS

_____
_____
_____
_____
_____
_____
_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ **Date** _____

Reviewed by (doctor) _____ Date _____

MOSENG CHIROPRACTIC

Informed Consent to Chiropractic Treatment

Patient Name _____ **Date** _____

Overview of Chiropractic: Chiropractic is a natural, non-drug, non-surgical form of healthcare. The primary treatment technique chiropractors use is called the "adjustment" or "manipulation". Manipulation by chiropractors is one of the most conservative, least invasive and safest procedures in the provisions of healthcare services. The risks of manipulation pale when compared to known medical risks.

The Nature of Chiropractic Treatment: The doctor will use his hands or a mechanical device to adjust your joints. You may feel a "click" or "pop", such as the noise produced when a knuckle is "popped", and you may feel movement of the joint. Various ancillary procedures, such as hot/cold packs, interferential, therapeutic ultrasound, deep tissue massage and exercises may also be used.

Possible Risks: As with any healthcare procedure, complications are possible following a chiropractic manipulation. A minority of patients may notice stiffness or soreness after the first few days of treatment. Other, much more remote possible complications may include muscular strains, ligamentous injury, fractures of bone or injury to the inter-vertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur in the event of serious injury to the arteries of the neck. The ancillary procedures, hot/coid packs and interferential could produce irritation, burns or other minor complications.

Probability of Risks Occurring: The risks of substantial complications due to chiropractic treatment have been described as "rare" in scientific literature, occurring much less often than complications seen form taking aspirin. The risks of Cerebrovascular injury, or stroke, has been estimated at one in three million to one in five million and can be further reduced by screening procedures, which you will undergo if vascular complications are suspected. The probability of adverse reaction due to ancillary procedures is also considered "rare" in scientific literature.

Other treatment options which could be considered include the following:

1. *Over-the-Counter Analgesics: The* risks of these medications include ulcers, irritation to the stomach, liver and kidneys, and other side affects in a significant number of cases.

2. *Medical Care:* Typically consists of anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

3. *Hospitalization:* In conjunction with medical care, hospitalization adds risk of exposure to virulent communicable disease in a significant number of cases.

4. *Surgery:* In conjunction with medical care and hospitalization, surgery adds the risks of adverse reaction to anesthesia as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me:

_____

_____

I have read the explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

Patient Signature _____ **Date** _____

MOSENG CHIROPRACTIC

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

Patient Signature _____ **Date** _____