

# 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 \_\_\_\_\_

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) \_\_\_\_\_

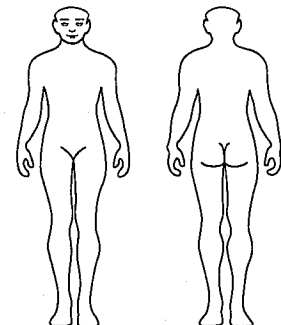
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

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

## ALLERGIES

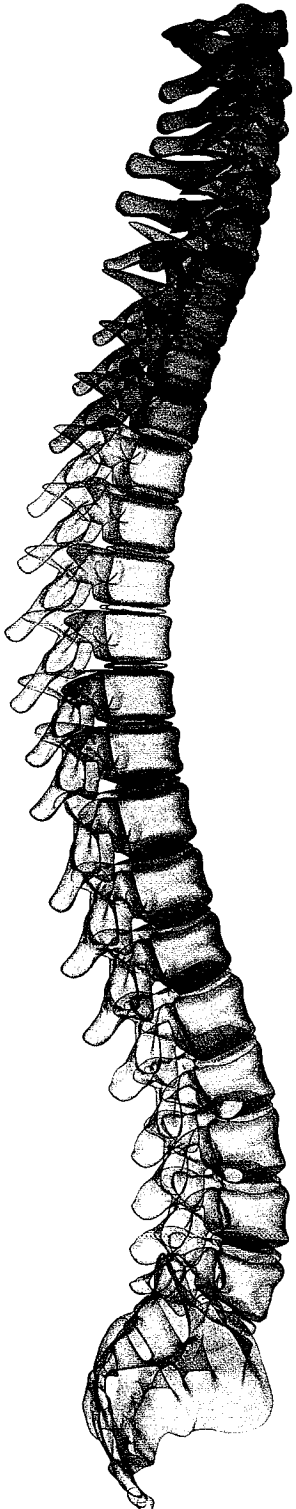
## VITAMINS/HERBS/MINERALS

_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

# Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS					
		PAST	PRESENT				
<b>Cervical</b>	• Autonomic Nervous System	<input type="checkbox"/>	<input type="checkbox"/>	Colic & Excessive Crying	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy & Seizures
	• ENT System	<input type="checkbox"/>	<input type="checkbox"/>	Ear & Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	Sensory & Spectrum
	• Vision, Balance & Coordination	<input type="checkbox"/>	<input type="checkbox"/>	Allergies & Congestion	<input type="checkbox"/>	<input type="checkbox"/>	ADD / ADHD
	• Speech	<input type="checkbox"/>	<input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Focus & Memory Issues
	• Immune System	<input type="checkbox"/>	<input type="checkbox"/>	Headaches & Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety & Stress
	• Digestive System	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo & Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Balance & Coordination
	• Nerve Supply to Shoulders, Arms & Hands	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat & Strep	<input type="checkbox"/>	<input type="checkbox"/>	Speech Issues
	• Sympathetic Nucleus	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Tonsils & Adenoids	<input type="checkbox"/>	<input type="checkbox"/>	TMJ / Jaw Pain
	• Metabolism	<input type="checkbox"/>	<input type="checkbox"/>	Vision & Hearing Issues	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck & Shoulders
		<input type="checkbox"/>	<input type="checkbox"/>	Low Energy & Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Depression
		<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
		<input type="checkbox"/>	<input type="checkbox"/>	Pain, Numbness & Tingling in Arms to Hands	<input type="checkbox"/>	<input type="checkbox"/>	Poor Metabolism & Weight Control
	<b>Upper Thoracic</b>	• Upper G.I.	<input type="checkbox"/>	<input type="checkbox"/>	Reflux / GERD	<input type="checkbox"/>	<input type="checkbox"/>
• Respiratory System		<input type="checkbox"/>	<input type="checkbox"/>	Chronic Colds & Cough	<input type="checkbox"/>	<input type="checkbox"/>	Functional Heart Conditions
• Cardiac Function		<input type="checkbox"/>	<input type="checkbox"/>	Asthma			
<b>Mid Thoracic</b>	• Major Digestive Center	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Pain / Issues	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion & Heartburn
	• Detox & Immunity	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Pains & Ulcers
		<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Blood Sugar Problems
<b>Lower Thoracic</b>	• Stress Response	<input type="checkbox"/>	<input type="checkbox"/>	Behavior Issues	<input type="checkbox"/>	<input type="checkbox"/>	Allergies & Eczema
	• Filtration & Elimination	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions / Rash
	• Gut & Digestion	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
	• Hormonal Control	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Stress	<input type="checkbox"/>	<input type="checkbox"/>	Gas Pain & Bloating
<b>Lumbar, Sacrum &amp; Pelvis</b>	• Lower G.I. (Absorption & Motility)	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica & Radiating Pain
	• Gut-Immune System	<input type="checkbox"/>	<input type="checkbox"/>	Chrohn's, Colitis & IBS	<input type="checkbox"/>	<input type="checkbox"/>	Lumbopelvic / SI Joint Pain
	• Major Hormonal Control	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Hamstring Tightness
		<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	Disc Degeneration
		<input type="checkbox"/>	<input type="checkbox"/>	Bladder & Urination Issues	<input type="checkbox"/>	<input type="checkbox"/>	Leg Weakness & Cramps
		<input type="checkbox"/>	<input type="checkbox"/>	Cramps & Menstrual Issues	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation & Cold Feet
		<input type="checkbox"/>	<input type="checkbox"/>	Cysts & Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Knee, Ankle & Foot Pain
		<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Weak Ankles & Arches
		<input type="checkbox"/>	<input type="checkbox"/>	Impotency	<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain
		<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Gluten & Casein Intolerance

Patient Name: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



**Culebra Chiropractic Clinic**  
8127 Culebra Road  
San Antonio, TX. 78251  
(210) 684-2313

## **INFORMED CONSENT FOR CHIROPRACTIC CARE**

To the patient (or their parent, legal guardian, court appointed conservator, or agent): Please read this entire form prior to signing it. It is important that you understand the information contained in this form. Please ask any questions prior to signing this form if you are unclear about anything in this form.

### **Chiropractic Adjustments -**

The primary treatment rendered by the Doctor of Chiropractic to you will be chiropractic adjustments, which are purposely intentioned movements of bones with the desired effect being to remove interference to nerves, which then allows your body to use its innate ability to heal itself. Chiropractic adjustments also have the desirable effect enabling muscles, tendons, and ligaments to properly function and heal, and also allows blood flow to properly occur. Chiropractic adjustments can be made by either the use of hands or mechanical instruments to any bone or joint in the body including both spinal and extremity bones. You may or may not hear an audible sound, which is just air being released from the joint space as bones are moved into their proper positions.

### **Other Procedures -**

There are a number of other procedures used by Doctors of Chiropractic that may be used on you. A physical examination will be performed to obtain a baseline level of functioning as well to partially determine an appropriate course of treatment and associated recommendations. The physical examination may include posture checks, range of motion testing, muscle strength testing, various neurological and orthopedic testing, and other testing. Radiology is the use of x-rays on the human body and is used to gain an inside perspective of the human body that cannot be obtained from a physical examination. Treatment may include chiropractic adjustments, physical therapy (such as ultrasound, interferential therapy, massage therapy, exercise recommendations, etc.). Additionally, there may be referrals to other doctors as necessary, and their treatment should involve the same informed consent with disclosure of risks and benefits as is being done here. For example, there can be permanent pain as a side effect of surgery as one possible consequence of that procedure.

### **Potential Benefits of Chiropractic and Associated Care -**

The vast majority of chiropractic patients tend to achieve good to excellent improvement in their physical conditions with chiropractic care. Improvement can be measured in many different ways, including reduction in pain, increased range of motion, less stiffness, increased athletic performance, and other ways. It must be remembered that different people get different results, different people have different pre-existing conditions, and are of different ages and occupations (with different types of physical stress). Your situation is unique, and no guarantees are given. You will have to determine what results you get for yourself and report them to your Doctor of Chiropractic.

### **Material risks Inherent with Chiropractic Adjustments and Other Treatment -**

As with any healthcare procedure, there are certain complications which may arise when chiropractic adjustments and other care/procedures are performed. These complications include but are not limited to fractures of bones, disc injuries, dislocations, muscle strains, cervical myelopathy, strokes, radiation exposure, costovertebral strains and separations, and burns. Some patients feel some stiffness and/or soreness following the first few days of treatment. The physical exam can temporarily worsen symptoms, but is a necessary part of chiropractic care. The Doctor of Chiropractic will make every reasonable effort during the examination to screen for contraindications to care, but remember it is your responsibility to inform the Doctor of Chiropractic of any conditions that would not otherwise come to their attention.

### **Probability of Risks Occurring -**

Fractures are rare occurrences and generally result from some underlying weakness of bone. Even though a competent history, examination (which may include radiography) will be performed, it is still possible for some weaknesses of bone to be undetected. Extremely rare are strokes from vertebral artery dissection which also occur in about one person in 133,000 in general (not related to chiropractic), but are estimated to occur in between one in one million and one in five million cervical adjustments. Although discs are generally helped with chiropractic care, they can be worsened even to the point of requiring surgical care (although this rarely occurs). Physical therapy can sometimes burn skin by irritating it, although this is unlikely to occur.

A perspective on the risks of chiropractic care as compared to medical care can be seen by the money paid by different doctors for a \$1,000,000 malpractice liability policy. The following annual premiums listed are close approximations, although not exact. A general medical doctor pays about \$20,000 per year, an internal medicine specialist pays about \$50,000 per year, and medical specialists such as surgeons, cardiologists, and obstetrics and gynecologists (OBGYN) pay about \$150,000 per year for a \$1,000,000 malpractice liability policy. In stark contrast to medical doctors who patients encounter significant more risk than Doctors of Chiropractic, Doctors of Chiropractic in California pay about \$3,000 per year. Also, it has been reported that about 187,000 deaths occur every year from medical malpractice, but that the number for chiropractic is typically zero per year.

### **Consequences of Not Obtaining Chiropractic Care -**

Not obtaining chiropractic care will have the effect of not obtaining its benefits such as having your body function at its best ability, reducing pain, peak athletic performance, etc. Not obtaining chiropractic care may allow 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, requiring more time (and money), and less effective when chiropractic care is obtained later in time. Not obtaining chiropractic care following trauma such as whiplash or other effects of automobile accidents will cause injured muscles, tendons, and ligaments to heal improperly and be significantly weaker and more prone to reinjury as compared to receiving proper chiropractic care.

### **Alternatives to Chiropractic Care -**

Other treatment options for your condition may include rest, acupuncture, physical therapy, medical care, medications (both over the counter and prescribed), hospitalization, and surgery, and others. If you choose to use other treatment options, you should discuss the risks and benefits with your medical doctor or other provider.

**DO NOT SIGN THIS FORM UNTIL YOU HAVE READ AND UNDERSTAND THIS FORM. UPON DOING SO, PLEASE COMPLETE THE INFORMATION AND SIGN THIS FORM.**

\_\_\_\_\_  
Signature of Patient,

\_\_\_\_\_  
Date

Guardian, Conservator, or Agent

\_\_\_\_\_  
Patient's Printed Name



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## Verification of Non-Pregnancy

By signing this form, I am verifying that I am not pregnant, and pregnancy is not suspected at this time.

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_  
(printed)

Signature: \_\_\_\_\_