VAN METRE CHIROPRACTIC REGISTRATION

(PLEASE PRINT)

Patient Name_____ Date of Birth_____ Age_____

Local Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone _____

Email _____

Are you a "**Snowbird**" – (part-time residence of Arizona) YES_____ NO_____

If you are "**Snowbird**", during what months are you usually in Arizona? _____

Patient SSN# _____ - _____ - _____ *(required for insurance purposes)*

Male____ Female____ Single____ Married____ Widowed____

Retired? YES_____ NO_____

Current/Previous Occupation_____

Emergency Contact Information

Contact Name _____ Relationship_____

Home Phone _____ Cell Phone _____

Insurance Information:

Primary Insurance Company _____ Phone _____

ID/Member# _____ Group# _____ Insured's Name _____

Secondary Insurance Company _____ Phone _____

ID/Member# _____ Group# _____ Insured's Name _____

Assignment and Release:

I the undersigned certify that I (or my dependent) have insurance coverage with the insurance companies listed above, and assign directly to Van Metre Chiropractic all insurance benefits, if any, for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Patient/Responsible party agrees that in the event of non-payment, all costs of collections if necessary, including attorney and court costs, plus interest, shall be the full responsibility of the patient.

I understand that I am financially responsible for all remaining charges not paid by insurance companies.

_____/_____/_____

Patient Signature/Responsible party of minor Relationship Date

OVER →

VAN METRE CHIROPRACTIC

PATIENT HEALTH INFORMATION and CONSENT FORM

We want you to know how your Patient Health Information **(PHI)** is going to be used in our office and your rights concerning those records. Before we begin any health care services we require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow Van Metre Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, and coordination of care. As an example, the patient agrees to allow Van Metre Chiropractic to submit any requested PHI to the health insurance companies, provided to us by the patient for the purpose of payment. Please be assured that we will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to request a copy of his or her own health records. *Request of patient records must be in advance, and may take up to two weeks to produce. (files may be in storage)*

3. A patients written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. **Consent for Treatment for Massage – if suggested by Doctor:**

   If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure/strokes may be adjusted to my level of comfort. I further understand massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____/_____/_____

Patient Signature/Responsible party of minor | Relationship | Date

VAN METRE CHIROPRACTIC
CONFIDENTIAL HEALTH INFORMATION

Dr. Kirk Van Metre D.C. Dr. Amy Cannatta D.C.

***Patient Name** _____ **Date**_____

***Referred by: (if new patient)** _____

***Location of today's pain:** _____neck _____upper-back _____mid-back _____low-back _____shoulder
_____elbow _____wrist _____hip _____knee _____legs/foot

Pain Scale 1-10 (10 being worst)

*** 1 2 3 4 5 6 7 8 9 10**

***Vitals**

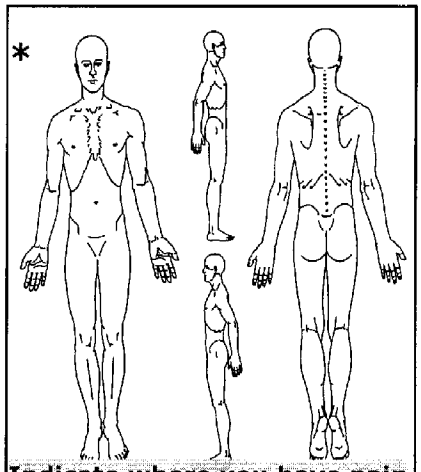
HEIGHT:_____FT_____IN

WEIGHT:_____LBS

AGE:_____

BLOOD PRESSURE:_____/_____
(120/80 considered normal range)

SMOKER: □ Yes □ No
- □ current every day smoker
- □ current some day smoker
- □ former smoker
- □ never smoked



Indicate where you have pain

CERVICAL	NORMAL	PAIN
Flexion	50	
Extension	60	
Left Lat Flex	45	
Right Lat Flex	45	
Left Rotation	80	
Right Rotation	80	
LUMBER	**NORMAL**	**PAIN**
Flexion	60	
Extension	25	
Left Lat Flex	25	
Right Lat Flex	25	
Left Rotation	30	
Right Rotation	30	

OFFICE USE ONLY

***Is today's problem caused by a recent Auto Accident?** □ **Yes** □ **No**

If yes, when/where: _____

***What is the number one thing that bothers you today?**

_____

***When did your pain begin?** □ _____**day(s) ago** □ _____**week(s) ago** □ _____**month(s) ago**
***Is your condition:** □ **getting better** □ **getting worse**
***Is your condition:** □ **on & off (or)** □ **constant**
***Type of pain:** □ **sharp** □ **stabbing** □ **burning** □ **achy** □ **dull** □ **stiff** □ **sore**
***Radiating: (does the pain travel)** □ **left /right** □ **base of skull** □ **shoulder** □ **arm** □ **hand** □ **hip** □ **leg** □ **knee** □ **foot** □ **ribs** □ **other**
***What makes it better:** □ **ice** □ **heat** □ **rest** □ **movement** □ **stretching**
***What makes it worse:** □ **sitting** □ **standing** □ **walking** □ **lying down** □ **sleep** □ **overuse**

ICD-10
Diagnosis: 1._____ 2._____ 3._____

4._____ 5._____ 6._____

Doctor's Initials:_____ Onset Date_____

13927 W. Grand Ave, Ste.402, Surprise, AZ 85374 Phone (623) 209-2225 FAX (623) 584-2311

OVER →

*** For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss	□	□ Osteoporosis
□	□ Ankle/Foot Pain	□	□ Loss of Appetite		
□	□ Jaw Pain	□	□ Abdominal Pain		
□	□ Joint Pain/Stiffness	□	□ Ulcer	**For Females**	
□	□ Arthritis	□	□ Hepatitis		
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder	□	□ Birth Control Pills
□	□ Cancer	□	□ General Fatigue	□	□ Hormonal Replacement
□	□ Tumor	□	□ Muscular Incoordination	□	□ Pregnancy
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		

* **Any surgeries to spine or other joints?** □ **Yes** □ **No**

If yes, when and why:_____

* **Have you been hospitalized within the past year?** □ **Yes** □ **No**

If yes, when and why:_____

* **Have you had any spinal x-rays/MRI within the past 2 years?** □ **Yes** □ **No**

If yes, when and where:_____

* **Have you had any massage treatment?** □ **Yes** □ **No**

If yes, when and where was your last massage:_____

* **Do you have a pacemaker or defibulator implanted?** □ **Yes** □ **No**

* **Do you take a blood thinner?** □ **Yes** □ **No**

* **Have you seen anyone else for this condition?** □ **Chiropractor** □ **Medical Doctor**

□ **Physical Therapist** □ **Massage Therapist** □ **Other**_____

*_____

Patient Signature / Responsible Party if minor Relationship Date

FUNCTIONAL RATING INDEX

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, please **circle the answer** which most closely describes your condition right now. If the category does not apply, please skip.

	0	1	2	3	4
PAIN INTENSITY	No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst possible pain
SLEEPING	Perfect Sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
PERSONAL CARE (washing, dressing, etc)	No Pain No Restrictions	Mild Pain No Restrictions	Moderate Pain; need to go slowly	Moderate Pain; need some assistance	Severe Pain; need 100% assistance
TRAVEL (driving, etc)	No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips
WORK	Can do usual work plus unlimited extra work	Can do usual work, no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work
RECREATION	Can do all activities	Can do most activities	Can do some activities	Can do few activities	Cannot do any activities
FREQUENCY OF PAIN	No Pain	Occasional pain 25% of day	Intermittent pain 50% of the day	Frequent pain 75% of the day	Constant pain 100% of the day
LIFTING	No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
WALKING	No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain any distance
STANDING	No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 30 minutes	Increased pain with any standing

Patient Signature _____ Date _____

Doctors Signature _____ Date _____

office use only

Total Score _____

= _____%