East Valley Spinal Decompression Center, L.L.C.
4915 E. Baseline Rd., Ste.101 Gilbert, AZ 85234 (480) 246-1068 Fax (480) 926-7101

Patient Registration and History Questionnaire

Name: _____ Age: _____Date of birth: _____ Date: _____
LAST FIRST MIDDLE

Address: _____Social Security #: _____… Male … Female

City, State, Zip: _____Marital Status: … M … S … W … D # of Children_____

Home Phone (_____)_____Work Phone (_____) _____

Email: _____

Employer: _____ Spouse's Name: _____

Occupation: _____ Spouse's Employer: _____

In case of emergency, notify_____Relationship: _____ Phone (_____) _____

Chief Complaint or Reason for Office Visit: _____

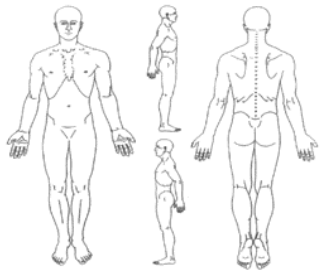
Specific Date and Time of Onset of Symptoms: _____

What makes your symptoms **better**? _____What makes your symptoms **worse**? _____

What is the quality of your symptoms? (**ache, burn, dull, sharp, throbbing**): _____

Are your symptoms local or do they travel to another area? (If they travel, to where?) _____

Are symptoms; …Constant >76% …Frequent 51-75% …Occasional 26-50% …Intermittent <25% **of your waking hours**

Please mark on the diagram to the right the following symbols as they relate to your symptoms: SS = spasms ST = stiffness DP = dull pain SP = sharp pain SH = shooting pain TI = tingling NU = numbness O = Other			

Please list all medications and dosage: **Frequency** **For What Illness?**

_____

_____

List any allergies to medications, foods or other: _____

Are you pregnant? … **Yes** … **No** First day of last menstrual cycle: _____

Do you smoke? … Yes … No; How much? _____ Do you drink alcohol? … Yes … No; How much? _____

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Patient's Name: _____ Date: _____

Please list all serious illness and serious accidents:	**Month and Year**	**City, State**

Please list any recent x-rays, lab or other tests:	**Date**	**Facility/Doctor**

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis … Yes	Lung Disease … Yes	Gout … Yes	Diabetes … Yes
Kidney Disease … Yes	Stomach/Ulcer … Yes	Heart Disease … Yes	Hepatitis … Yes
Sciatica … Yes	Blood Pressure … Yes	Transfusion … Yes	Polio / MS … Yes
Colon Disease … Yes	Stroke … Yes	Cancer … Yes	Bleeding … Yes
Paralysis … Yes	Seizures … Yes	Arthritis … Yes	Asthma … Yes
Anemia … Yes	Thyroid Disease … Yes	Drug Dependence … Yes	AIDS … Yes

Any other condition(s) not listed above that the doctor should be made aware of:

_____

YOUR GROUP HEALTH INSURANCE COMPANY: _____

Address: _____ Telephone: (_____) _____ Insured: _____

Date of Birth: _____ Policy #: _____ SS#: _____

Telephone: (_____) _____ Fax: (_____) _____

HIPAA Compliance

Brian Self, DC is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Staff Initials: _____

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Informed Consent

The nature of the chiropractic manipulation: I will use either my hands an instrument or both to move the joints of your body; this may result in an audible "pop" or "click".

The material risks inherent in an adjustment: As with any healthcare procedure, there are certain complications that may arise during a chiropractic manipulation. This may include: strains, dislocations, fractures, disc injuries and stroke. This list is not all inclusive.

The probability of those risks: Fractures are rare and can result from an underlying weakness in the bones. The other complications listed are considered rare. One source states that stroke is a possible occurrence in 1/1,000,000 cases or higher, even so we employ tests during our examination to identify if you may be susceptible to that kind of injury.

Ancillary treatments recommended: Ice, Moist Heat Packs, Ultrasound, Electrical Muscle Stimulations, Stretching/Strengthening Exercises, Massage Therapy, Diathermy, Laser, Neuromuscular Re-education, Graston Technique and Decompression Spinal Traction

Risks involved with the recommended ancillary treatments:
Ice, Heat and Electrical Muscle Stimulations (EMS) can cause burning. The EMS can cause skin irritation underneath the active pads. Stretching/Strengthening Exercises and Decompression Spinal Traction can cause temporary post-treatment soreness or reflex muscle spasms. Graston technique can cause mild bruising and skin redness. This list is not all inclusive.

Other treatment options for your condition can include: Medical care with prescription drugs, self management with over-the-counter medication, rest, and/or surgery. There are material risks inherent in each of these options including but not limited to: addiction to medication, side effects of medication, improper self dosages and surgical risks including complications from either the procedure and the anesthesia.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the chiropractic adjustment and the related treatment. I have discussed it with the doctor 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 I have decided that it was in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Patient Printed Name_____ **Date**_____

Patient Signature_____

The patient had the following questions and was supplied the following answers:

_____

_____

It is my clinical opinion this patient is oriented to time and place: Yes No

It is my clinical opinion this patient was able to understand the language involved: Yes No

Dr. Signature _____

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Patient RF Questionnaire

Patient _____ Date _____Age _____

Please check the appropriate response. If "yes", please explain. If you are not sure, check the "?" box. ***THANK YOU!***

NO	YES	?	
☐	☐	☐	Do you have a past history of cancer?
☐	☐	☐	Have you had any unexplained weight loss?
☐	☐	☐	Does your pain improve with rest?
☐	☐	☐	Are you over 50 years old?
☐	☐	☐	Failure to respond to a course of conservative care (4-6 weeks)?
☐	☐	☐	Have you had spinal pain greater than 4 weeks?

NO	YES	?	
☐	☐	☐	Prolonged use of corticosteroids (such as organ transplant Rx)?
☐	☐	☐	Intravenous drug use?
☐	☐	☐	Current or recent urinary tract, respiratory tract or other infection?
☐	☐	☐	Immunosuppression medication &/or condition?

NO	YES	?	
☐	☐	☐	History of significant trauma?
☐	☐	☐	Minor trauma in person >50 years old?
☐	☐	☐	Do you have osteoporosis (weak bones)?
☐	☐	☐	Are you over 70 years old?
☐	☐	☐	Any history of prolonged use of corticosteroids?

NO	YES	?	
☐	☐	☐	Acute onset urinary retention or overflow incontinence (wet underwear)
☐	☐	☐	Loss of anal sphincter tone or fecal incontinence (bowel accidents)
☐	☐	☐	Saddle anesthesia (numbness in the groin region)
☐	☐	☐	Global or progressive muscle weakness in the legs (legs give out)

COMMENTS:_____
_____
_____
_____
_____
_____