Registration Form

Back To Life Chiropractic · 4201 W Highway 146 · LaGrange, KY 40031 · *(502) 241-1122*

Date _____ Act# _____

Patient Name _____

Last Name *First Name* *Middle*

E-Mail: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ *Preferred method of contact:* _____

Address: _____

City _____ State _____ Zip Code _____

Sex Male Female Children: Yes / No #:

Birthdate: _____ Age: _____

Married Widowed Single Minor Separated Divorced Partnered

Spouse/Parent Name: _____

Occupation _____

Patient Employer/School _____

In Case of Emergency, Contact: _____ Phone number: _____

Referred by: _____

If by internet, name of search engine and key words used:

Would you like to receive appointment reminders by phone, text or email? Yes or No Circle one: P T E

I would like to receive The Synapse: a monthly newsletter, updates and coupons by e-mail? Yes or No

Is condition due to an accident? Yes No Type of accident: Auto Work Home Other

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

FEMALE: Are you pregnant? Yes No **Due Date:**

Have you ever had chiropractic care before: Yes No If yes, when?

INSURANCE

PLEASE GIVE US YOUR INSURANCE CARD(S) TO BE COPIED & VERIFIED

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with _____(insurance company(ies)) and _____(any additional insurance company(ies)) and assign directly to Back To Life Chiropractic, PLLC 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. Back To Life Chiropractic, PLLC may use my health care information and may disclose such information to the above-names insurance company(ies) and their agents form the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative:_____

Print Name:_____

Who is responsible for this account?_____ Relationship to Patient:_____

Back to Life Chiropractic

Past History

Name:_____

Date:_____

Health History	Please check box if you have had any of the following:			Write a C in the box if health problem is current.
☐ Aids/HIV	☐ Chicken Pox	☐ Liver Disease	☐ Rheumatoid Arthritis	☐ Chemical Dependency
☐ Alcoholism	☐ Diabetes	☐ Measles	☐ Rheumatic Fever	☐ Kidney Disease
☐ Allergy Shots	☐ Emphysema	☐ Migraine Headaches	☐ Scarlet Fever	☐ Psychiatric Care
☐ Anemia	☐ Epilepsy	☐ Miscarriage	☐ Stroke	☐ High Cholesterol
☐ Anorexia	☐ Fractures	☐ Mononucleosis	☐ Suicide Attempt	☐ Prosthesis
☐ Appendicitis	☐ Glaucoma	☐ Multiple Sclerosis	☐ Thyroid Problems	☐ Whooping Cough
☐ Arthritis	☐ Goiter	☐ Mumps	☐ Tonsillitis	☐ Cataracts
☐ Asthma	☐ Gonorrhea	☐ Osteoporosis	☐ Tuberculosis	☐ Herpes
☐ Bleeding Disorders	☐ Gout	☐ Pacemaker	☐ Tumors, Growths *Type*:	☐ Prostate Problems
☐ Breast Mass	☐ Heart Disease	☐ Parkinson's Disease	☐ Typhoid Fever	☐ Herniated Disk
☐ Bronchitis	☐ Hepatitis	☐ Pinched Nerve	☐ Ulcers	☐ Polio
☐ Bulimia	☐ Hernia	☐ Pneumonia	☐ Vaginal Infections	☐ Venereal Disease

☐ Cancer *Type:* ☐ Articular hyper mobility or joint instability of the spine ☐ Severe demineralization of bone

☐ Benign bone tumors (spine) ☐ Bleeding disorders and anticoagulant therapy ☐ Acute arthropathies

☐ Acute fractures and dislocations or healed fractures and dislocations with signs of instability of the spine

☐ Acute rheumatoid arthritis ☐ Ankylosing spondylitis ☐ An unstable os odontoideum

☐ Malignancies of the vertebral column ☐ Infection of bones or joints of the vertebral column

☐ Radiculopathy with progressive neurological signs ☐ Other_____

	Date/Description:
Falls	_____
Head Injuries	_____
Broken Bones	_____
Surgeries	_____

FAMILY HISTORY
Please describe:

Is there any family history of the above problems? Yes No

EXERCISE:	**WORK ACTIVITY:**	**HABITS:**	
None	Sitting	Smoking	Packs/Day:
Moderate	Standing	Alcohol	Drinks/Week:
Daily	Light Labor	Coffee/Caffeine Drinks	Cups/Day:
Heavy	Heavy Labor	High Stress Level	Reason:

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS**

Name:_____ Date:_____

Complaint 1:_____

For How Long?_____

What originally caused this problem?_____

Feels Like: □ Aching □ Burning □ Dull □ Pulling □ Sharp □ Shooting □ Stabbing □ Stinging

□ Throbbing □ Numbness □ Pins and Needles □ Cramps □ Other_____

Bothers Me: □ Constant (100%) □ Frequent (50%-75%) □ Intermittent (25%-50%) □ Occasional(1%-25%)

It Has Been: □ Getting Worse □ Staying Same □ Getting Better

Pain Scale: (0=No Pain - 10 Severe Pain)

Last 24 Hours: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Past 1-4 Weeks: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

During the Day it is: □ Worse in the AM □ Stays the same throughout the day □ Worse in PM

The Following Increases Pain:

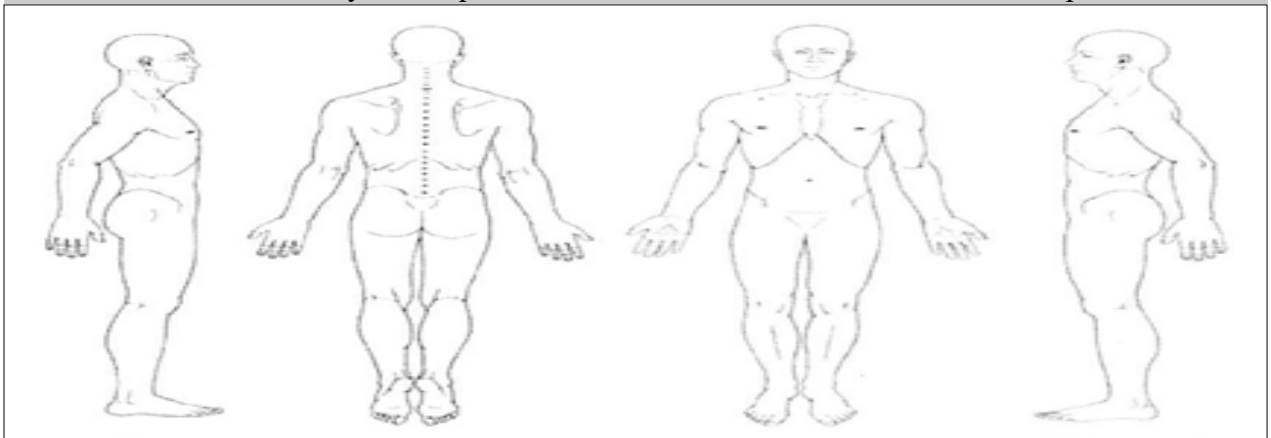
□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other_____

The Following Decreases Pain:

□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other_____

Does the Pain Travel/Radiate?: □ Yes □ No If yes, where: _____to_____

Mark an "X" on the areas you feel pain for *this* condition & Draw an arrow if the pain travels:



How much has your condition interfered with your daily activities (including both work outside, and housework)**:**

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely ***What Activities:***

How much has your condition interfered with your social activities:

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely ***What Activities:***

Does your condition interfere with any of the following:

□ *Work* □ *Sleep* □ *Daily Routine* □ *Recreation* □ *Computer Use* □ *Sports* □ *Reading* □ *Exercise* □ *Vacuuming*

□ *Cleaning* □ *Cooking* □ *Watching Kids/Grand kids* □ *Yard Work* □ *Driving* □ *Relationship* □ *Shopping*

□ *Gardening* □ *School* □ *Self Care* □ *Other*_____

List other doctors consulted for *this* condition including x-rays, CT scans, MRI and etc.:

1. 2.

3. 4.

List of current medications/supplements taking for *this* condition:

Name:_____ Date:_____

Complaint 2:_____

For How Long?_____

What originally caused this problem?_____

Feels Like: □ Aching □ Burning □ Dull □ Pulling □ Sharp □ Shooting □ Stabbing □ Stinging

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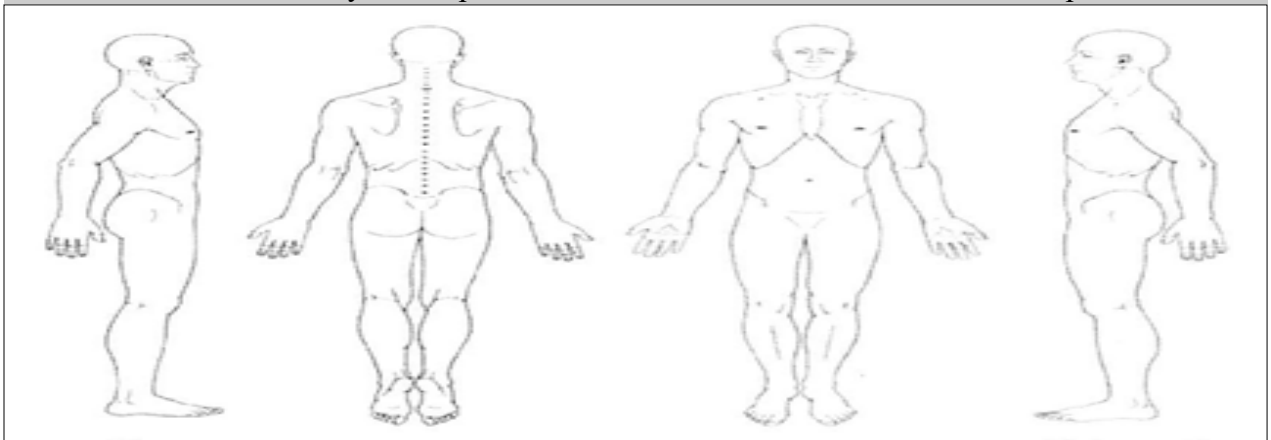

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Complaint 3:_____

For How Long?_____

What originally caused this problem?_____

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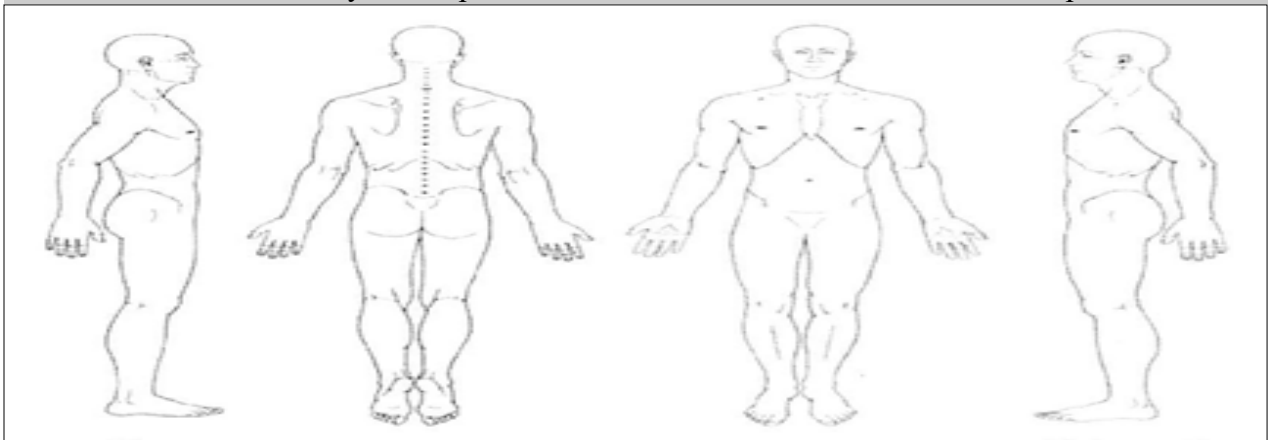

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Back to Life Chiropractic

Name:_____ Date:_____

Concerns:	
We've found that these are the common concerns people like you have. We want to make sure you are comfortable before we start care. Add any other that are relevant and **circle your top 3**.	
Is it going to hurt?	I don't want to be cracked.
Do I have to come forever?	Is it addictive?
Are the X-rays dangerous?	Is it safe for children?
Is it expensive?	What if insurance does not cover chiropractic?
What do I do if chiropractic does not work?	Can this be fixed?
Any others:	

Strengths:	
How would you say your overall health right now is: □ Excellent □ Very Good □ Good □ Fair □ Poor	
Strong habits are key to health. It helps us take care of you if we have an idea of how you take care of your body. Add any others that are relevant and **circle your top 3**.	
Stretch 3-5 times a week	Exercise 3-5 times a week
Drink 1/2 my body weight in of ounces of water	Take supplements for health
Have a positive attitude	Sleep 6-8 hours a night
Eat a anti-inflammatory diet	Get maintenance chiropractic 2-4 times a year
Do activities to minimize stress regularly	Non-smoker
Any others:	

Goals:	
We want to make sure you get lasting relief and enjoy maximum functional improvement. Add any other that are relevant and **circle your top 3**.	
Sleep through the night.	Exercise again:
Continue working/get back to work	Avoid future flare ups
Play with kids/grandkids normally	Get off pain medications
Be ready for an upcoming event	Have a better attitude
Have some moments of relief	Sit/stand comfortably for an extended period
Any others:	

Are you interested in Nutritional Services? (i.e, Zyto a computerized analysis of Galvanic skin currents, Urine PH, Balancing Body Chemistry symptom based computerized analysis and cleanses.) □ Yes □ No

Back To Life Chiropractic • 4201 W Highway 146 · LaGrange, KY 40031 • (502) 241-1122

Patient Authorization for the Use and Disclosure of Protected Health Information

_____ , herby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health Information ("PHI") necessary for Back to Life Chiropractic to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. Back to Life Chiropractic explained to me that the Privacy Notice will be available to me in the future at my request. Back to Life Chiropractic has further explained my right to obtain a copy of the Privacy Notice prior to my signing this Consent.
2. Back to Life Chiropractic reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with practical law.
3. I understand that, and consent to, the following appointment reminders that will be used by the practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for Back to Life Chiropractic to treat me and obtain payment for that treatment and as necessary for Back to Life Chiropractic to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Back to Life Chiropractic is not required to agree to any restrictions that I have requested. If Back to Life agrees to a requested restriction, then the restriction is binding on Back to Life Chiropractic.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that Back to Life Chiropractic has already taken action in reliance on this consent.
7. I understand that if I revoke this Consent at any time, Back to Life Chiropractic has the right to refuse treatment to me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent, if a minor) Relationship

Witness:_____

Back To Life Chiropractic

4201 W Highway 146 · Crestwood, KY 40031

www.BackToLifeChiropracticKY.com · 502.241.1122

Authorization For Examination

I, the undersigned, a patient in this office hereby authorize Dr. Mark R. Schuler, (and whomever he may designate as his assistants) to administer such examinations as is necessary, and to perform the following examination procedures as are considered necessary on the basis of findings during the course of said examination.

I, hereby certify that I have read and fully understand the above Authorization for Examination, the reasons why the above name examination is considered necessary, its advantages and possible complications, if any, which were explained to me by Dr. Mark R. Schuler. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Date:_____ Signed:_____

Witness:_____ Or:_____

(Nearest Relative)

Authorization For Chiropractic Treatment

I, the undersigned, a patient in this office hereby authorize Dr.Mark R. Schuler (and whomever he may designate as his assistants) to administer such treatment as is necessary, and to perform the following therapy and manipulation and such additional therapy or procedures as are considered necessary on the basis of findings during the course of said treatment.

I, hereby certify that I have read and fully understand the above Authorization for Chiropractic Treatment, the reasons why the above name treatment is considered necessary, its advantages and possible complications, if any, as well as possible alternative models of treatment, which were explained to me by Dr. Mark R. Schuler.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Date:_____ Signed:_____

Witness:_____ Or:_____

(Nearest Relative)