Valley Chiropractic
New Patient Registration Form

Date_____ **Cell Phone** _____ **Home Phone** _____

Patient Last Name _____ **First Name** _____

Address _____

City _____ **State** _____ **Zip** _____

Sex ☐ M ☐ F **Age** _____ **Birthdate** _____ **Social Security #**_____

Emergency Contact _____ **Phone** _____

Primary Care Physician _____ **Phone** _____

Present Complaint _____

Is this condition related to auto accident or work accident: ☐ Yes ☐ No

PATIENT PRIMARY INSURANCE INFORMATION	**Insurance Company** _____ **Member #** _____ **Insured's Name** _____ Birthdate _____ **Relationship to Insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other
SECONDARY INSURANCE INFORMATION	**Insurance Company** _____ **Member #** _____ **Insured's Name** _____ Birthdate _____ **Relationship to Insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other
PATIENT AGREEMENT	***Assignment and Release*** *Our office policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our office. If the account is not paid within 90 days of the date of service, and no financial arrangement has been made, you will be responsible for all expenses incurred in collecting your account. I hereby authorize payment of benefits directly to the provider of benefits due me for services rendered. I authorize the use of this signature on all my insurance submissions. I further authorize the physician and/or supplier to release any information required to process insurance claims.* _____ _____ Signature of Insured/Guardian Date

Valley Chiropractic
Health Questionnaire

Patient Name_____ **Date**_____

Reason for visit_____

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

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

What did they recommend?_____

When did your symptoms appear?_____ **Is this 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

☐ Recreational activities or movements that are painful to perform ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down

☐ Other _____

Your Occupation (Describe activities – sitting, lifting, etc.)_____

Non-job exercise _____Hrs/wk

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

Do you take ☐ Muscle relaxers ☐ Pain killers ☐ Insulin ☐ Birth Control Pills ☐ Over-the-counter meds
☐ Other prescription drugs *(Please list all medication in the space at bottom of the page.)*

Do you smoke? _____ If so, how much _____ How many years? _____
If stopped, how long did you smoke? _____ When did you stop? _____
Do you drink alcohol? _____ If yes, how much/often? _____
Any history of drug use? Past or present? _____

Date of last: Physical exam _____ Spinal x-ray _____ Blood test _____
Spinal exam _____ Chest x-ray _____ Urine test _____
Dental x-ray _____ MRI, CTScan, Bone scan _____

Sleep _____Hrs/night **Do you sleep on your** ☐ Back ☐ Side ☐ Stomach

Age of mattress _____ **or waterbed** _____ **Is your bed comfortable?** ☐ Yes ☐ No

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

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

CONDITIONS Check (✔) conditions 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 problems
☐ Arthritis	☐ Goiter	☐ Multiple sclerosis	☐ Tonsillitis
☐ Asthma	☐ Gonorrhea	☐ Mumps	☐ Tuberculosis
☐ Bleeding disorders	☐ Gout	☐ Osteoporosis	☐ Tumors, 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	☐ Whooping cough
☐ Chemical dependency	☐ HIV Positive	☐ Psychiatric care	☐ Other _____
☐ Chicken Pox	☐ Kidney disease	☐ Rheumatoid arthritis	_____

MEDICATIONS List medications you are currently taking	**VITAMINS/HERBS/MINERALS**
Allergies:	
Pharmacy Name	**Pharmacy Phone**

GENERAL SYMPTOMS Check (✔) symptoms you have or have had in the past year

GENERAL

- ☐ Bruise easily
- ☐ Chills
- ☐ Dental problems
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ 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

GASTROINTESTINAL

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

CARDOVASCULAR

- ☐ 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
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing ears
- ☐ Sinus problems
- ☐ 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 smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last Menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

NECK, BACK, EXTREMITIES Check (✔) symptoms 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 spasm in neck
- ☐ Grinding/popping sounds in neck

SHOULDERS

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

MID-BACK

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

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

ARMS & HANDS

	Right	Left
☐ Pain in upper arm	☐	☐
☐ Pain in elbow joint	☐	☐
☐ Pain in forearm	☐	☐
☐ Pain in hand	☐	☐
☐ Pain in hand	☐	☐
☐ Pain in fingers	☐	☐
☐ Pins & needles in fingers	☐	☐
☐ Numbness in arm	☐	☐
☐ Numbness in fingers	☐	☐
☐ Weakness of arm	☐	☐
☐ Weakness of hand	☐	☐
☐ Hands cold	☐	☐

HIPS, LEGS & FEET

	Right	Left
☐ Pain in buttocks	☐	☐
☐ Pain in hip joint	☐	☐
☐ Pain down leg	☐	☐
☐ Pain in knee	☐	☐
☐ Pain in ankle	☐	☐
☐ Pain in foot	☐	☐
☐ Weakness of leg	☐	☐
☐ Weakness of knee	☐	☐
☐ Leg cramps	☐	☐

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/her staff responsible for any errors or omissions that I may have made in the completion of this form.

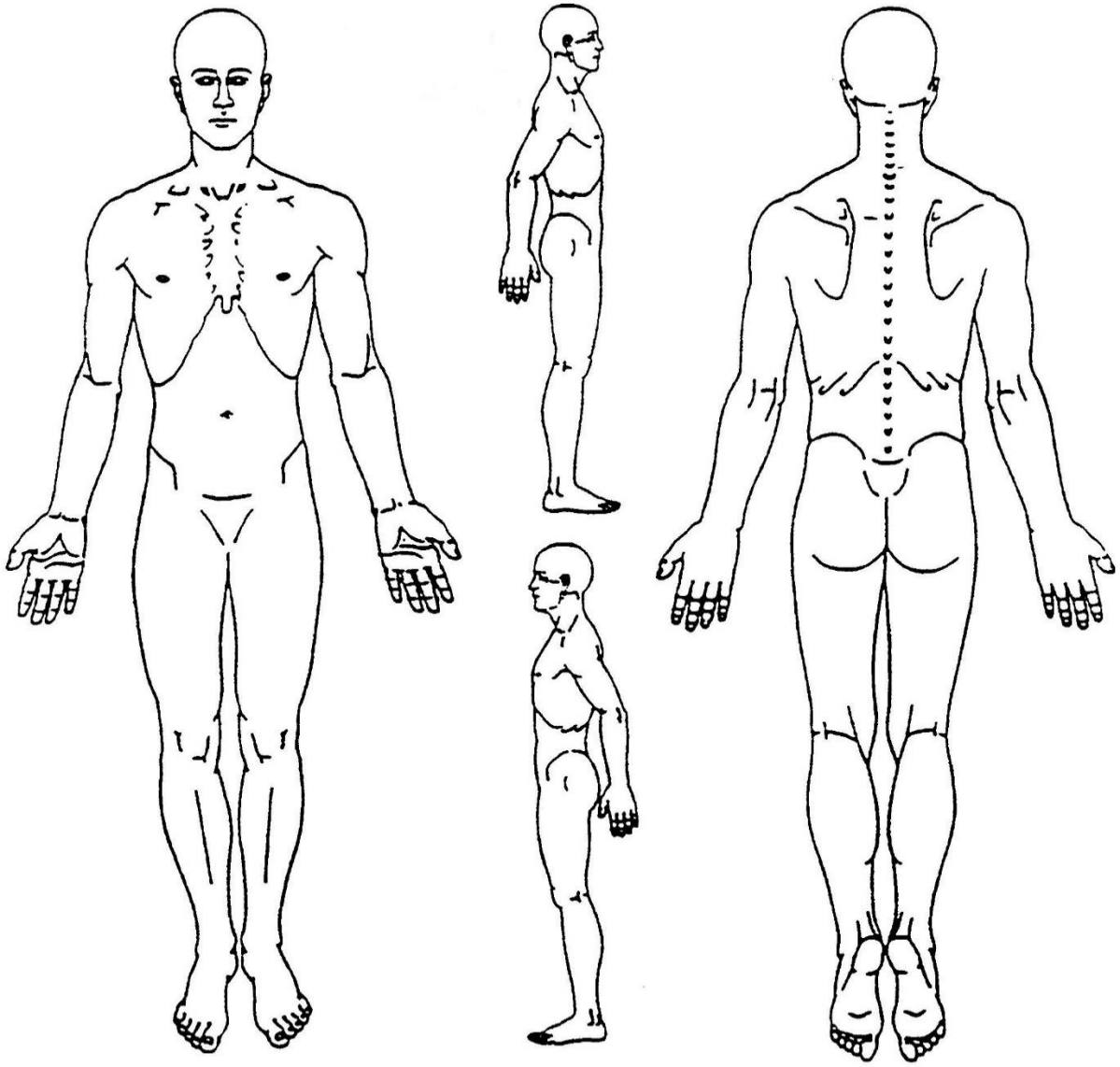
_____ _____

Patient Signature **Date**

PATIENT NAME: (Print) _____ Date _____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull	**S = Stabbing/Cutting**
B = Burning	**T = Tingling (Pins & Needles)**
N = Numb	**C = Cramping**



On the scales below, please draw a vertical line representing your pain or discomfort:

1. Rate the pain you have <u>RIGHT NOW</u>

NO PAIN UNBEARABLE PAIN

_____

2. Rate your pain at its <u>BEST</u> in the past week

NO PAIN UNBEARABLE PAIN

_____

3. Rate your <u>AVERAGE</u> pain in the past week

NO PAIN UNBEARABLE PAIN

_____

4. Rate your <u>WORST</u> pain in the past week

NO PAIN UNBEARABLE PAIN

_____

PATIENT NAME: (Print) _____ Date _____

This questionnaire can be used to quantify activity limitation and measure functional outcome for patients with an orthopedic condition. Please list any activities you are **having difficulty** with or are **unable to perform** because of your _____ problem.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

FOR DOCTOR ONLY:

Patient specific activity scoring scheme (Point to one number):

0 1 2 3 4 5 6 7 8 9 10

Unable to Perform Activity

Able to perform activity at the same level as Before injury Or problem

(Date and Score)

Activity	Initial					
1						
2						
3						
4						
5						
6						
Additional						

Follow-up assessments

When I assessed you on (state previous assessment date), you told me that you had difficulty with (read all activities from list). Today do you still have difficulty with (read and have patient score each item in the list)?

Interpretation of scores

Total score = sum of the activity scores/number of activities
Minimum detectable charge (90%CI) for average score = 2 points
Minimum detectable change (90%CI) for single activity score = 3 points

Source: Stratford P, Gill C Westaway M, Binkley J Assessing disability and change on individual patients: a report of a patient specific measure. Physiotherapy Canada 1995:47:258-63.

Valley Chiropractic Financial Policy

We are committed to providing you with the best possible care and we are pleased to discuss our services with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

INFORMATION:
Prior to receiving service, you must complete our Patient Information form and any necessary Medical History and Release forms, and provide your insurance card(s) for photocopying.

INSURANCE:
Insurance is a contract between you and your insurance company. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, "usual and customary" charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account.
We are authorized providers for most major insurance carriers and participate in many HMO, PPO, POS and indemnity plans. We will bill directly your primary carrier and will, if you provide us the information, bill any balance to your secondary insurance.

Pre-authorization and referrals – If your plan requires it, you must provide proper authorization from your primary care physician prior to receiving service. If authorization has not been obtained, we will gladly reschedule your appointment to a more convenient time.

Self-Pay - If you do not have insurance, payment in full is expected at each visit. If this is not possible, prior to your service we will work with you to arrange a payment plan. We accept cash, checks, money orders and Visa/MasterCard.

LITIGATION:
Patients involved in an auto accident, workmen's compensation or personal injury lawsuits are, as all other patients, responsible for their bills. We will, as a courtesy, send your lawyer a carbon-copy bill if you provide us with his name and address.

I have read the above policy and understand my responsibility for my account. I understand my insurance(s) may not cover this procedure and agree that I am responsible for the bill.

_____

Print Name

_____ _____

Signature **Date**

Informed Consent Document

Please read prior to signing. It is important that you understand the information before you sign.

The nature of the chiropractic adjustment.
The primary treatment we use as a Doctor of Chiropractic is spinal manipulative therapy. This procedure will be comprised of either the use of my hands or a mechanical instrument upon your body in such a way as to restore motion to the joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment
As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

spinal manipulative therapy	*palpation*	*vital signs*
range of motion testing	*orthopedic testing*	*basic neurological testing*
muscle strength testing	*postural analysis*	*ultrasound*
hot/cold therapy	*electrical muscle stimulation*	*radiographic studies*

The material risks inherent in chiropractic adjustment
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some reasonable effort during the examination to screen for contraindications to care, however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.
Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the 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 and less effective the longer it is postponed.

PLEASE DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Stephen Puzio 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 have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks. I hereby give my consent to that treatment.

Date _____

Print Patient's Name _____

Signature _____

_____
Signature of Parent or Guardian

Authorization to Release Protected Health Information

Valley Chiropractic Health Center
7460 Lancaster Pike, Suite 8
Hockessin, DE 19707
302-234-4045; Fax 302-234-4046

By signing below I authorize the above-named practice to use and/or disclose the following Protected Health Information (PHI):

- Medical/Chiropractic Information
- Financial Information
- Insurance Information
- Appointments

I authorize the above-named practice to disclose this information to the following:

_____

_____

This information may be used for the purpose of provider transfer, research or at patient's request.

I understand once my information is released, it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying, in writing, the above named practice. However, a revocation will not affect any actions taken by the above-named practice prior to its receipt of the revocation.

This authorization expires _____.

I understand the practice will not condition treatment on whether I sign this authorization form, except in the following situations:

- If the medical information to be disclosed will result in treatment for research purposes, the practice will not provide the treatment if I am unwilling to sign this authorization form.

-If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, the practice will not provide the treatment if I am unwilling to sign this authorization form.

I will receive a copy of this completed and signed authorization form.

Date _____

Signature of Patient,
Parent, Guardian or Personal Representative _____

Relationship to Patient _____

Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information

Valley Chiropractic Health Center
7460 Lancaster Pike, Suite 8
Hockessin, DE 19707

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Valley Chiropractic Health Center may use or disclose my protected health information for treatment, payment, or health care operations, which means providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Valley Chiropractic Health Center has a detailed document called the "Notice of Privacy Practices". It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the "Notice" before signing this agreement. If I ask, Valley Chiropractic will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Valley Chiropractic Health Center to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Valley Chiropractic Health Center has taken action relying on this consent.

Signature _____ **Date** _____

Relationship to Patient _____ **Date** _____
If signed by another party

You may obtain a copy of our Notice of Privacy Practices, including any revisions or our "Notice" at any time by contacting us at 302-234-4045.

MEDICAL RECORDS RELEASE REQUEST

I authorize you to release confidential health information about me by releasing a copy of or a summary or narrative of my protected health information to:

Valley Chiropractic Health Center – Phone 302-234-4045; Fax 302-234-4046.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

☐ Complete Records ☐ History & Physical ☐ Progress Notes

☐ Care Plan ☐ Lab Reports ☐ Radiology Reports

☐ Pathology Reports ☐ Treatment Record ☐ Operative Reports

☐ Hospital Reports ☐ Medication Record ☐ All of the Above _____

☐ Other _____

Signature _____ Date _____