CHIROPRACTIC REGISTRATION & HISTORY

1. Patient Information

Date:_____

Patient:_____

Address: _____
_____

Sex: __ M __ F Age:___ Birth-date:_____

__ Single ___ Married ___Widowed ___Separate ___Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer's Address_____

Employer's Phone _____
Spouse's _____

Birth-date_____ **SS#**_____

Occupation_____

Spouse's Employer _____

Whom may we thank for referring you? _____

EMAIL _____

2. Insurance

Who is responsible for this account? _____

Relationship to patient_____

Insurance Co. _____

Group# _____

Is patient covered by additional insurance ___ YES ___NO

Subscriber's Name _____

Birth-date _____ ***SS#*** _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) 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 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.***

_____
Responsible Party Signature

_____
Relationship To Patient ***Date***

3. PHONE NUMBERS

Home _____ ***Work*** _____ ***Ext*** ____

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

Type of accident ____ AUTO ____ WORK _____ HOME _____ OTHER

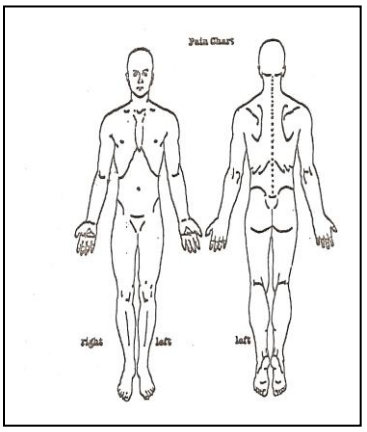
To Whom have you made a report of your accident?

____ AUTO INS. ____ EMPLOYER ___ WORKER COMP

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
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 movement that are painful to perform?
____ SITTING ____ STANDING _____ WALKING ____ BENDING _____ LYING DOWN



CHIROPRACTIC REGISTRATION & HISTORY

6. HEALTH HISTORY

Name: _____ ***Date:*** _____ ***Patient#:*** _____

What treatment have you already received for your condition? _____ ***Medication*** ____ ***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 __ Yes __ No	*Emphysema __ Yes __ No*	*Miscarriage __ Yes __ No*	*Scarlet Fever __ Yes __ No*
Alcoholism __ Yes __ No	*Epilepsy __ Yes __ No*	*Mononucleosis __ Yes __ No*	*Stroke __ Yes __ No*
Allergy Shot __ Yes __ No	*Fractures __ Yes __ No*	*Multiple Sclerosis __ Yes __ No*	*Suicide Attempt ___ Yes ___ No*
Anemia ___ Yes __ No	*Glaucoma __ Yes __ No*	*Mumps __ Yes __ No*	*Thyroid Problems ___ Yes ___ No*
Anorexia __ Yes ___ No	*Goiter __ Yes __ No*	*Osteoporosis __ Yes __ No*	*Tonsillitis __ Yes ___No*
Appendicitis __ Yes __ No	*Gonorrhea __ Yes __ No*	*pacemaker __ Yes __ No*	*Tuberculosis __ Yes __ No*
Arthritis __ Yes __ No	*Gout __ Yes __ No*	*Parkinson's Disease __ Yes __ No*	*Tumors, Growth __ Yes __ No*
Asthma __ Yes __ No	*Heart Disease __ Yes __ No*	*Pinched Nerve __ Yes __ No*	*Typhoid Fever __ Yes __ No*
Bleeding DO __ Yes __ No	*Hepatitis __ Yes __ No*	*Pneumonia __ Yes __ No*	*Ulcers __ Yes __ No*
Breast Lump __ Yes __ No	*Herniated Disk __ Yes __ No*	*Polio __ Yes __ No*	*Vaginal Infections __ Yes __ No*
Bronchitis __ Yes __ No	*Herpes __ Yes __ No*	*Prostate Problem __ Yes __ No*	*Venereal Disease __ Yes __ No*
Bulimia __ Yes __ No	*High Cholesterol __ Yes __ No*	*Prosthesis __ Yes __ No*	*Whooping Cough __ Yes __ No*
Cancer __ Yes __ No	*Kidney Disease __ Yes __ No*	*Psychiatric Care __ Yes __ No*	*Cataracts __ Yes __ No*
Chem. Depend. __ Yes __ No	*Liver Disease __ Yes __ No*	*Rheumatoid Arthritis __ Yes __ No*	*Chicken Pox __ Yes __ No*
Measles __ Yes __ No	*Rheumatic Fever __ Yes __ No*	*Diabetes __ Yes __ No*	*Migraine Headaches __ Yes __ No*

EXERCISE
___ NONE
___ MODERATE
___ DAILY
___ HEAVY

WORK ACTIVITY
___ SITTING
___ STANDING
___ LIGHT LABOR
___ HEAVY LABOR

HABITS
___ SMOKING PACKS/DAY_____
___ ALCOHOL DRINKS/WEEK _____
___ COFFEE/CAFFEINE 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

_____

_____

PHARMACY NAME: _____
PHARMACY PHONE: _____

ALLERGIES

_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____

PATIENT'S NAME: _____ DATE: _____

NECK pain >> radiating pain into L / R shoulder / arm / wrist / hand
0----1-----2-----3-----4------5------6------7------8-------9-----10

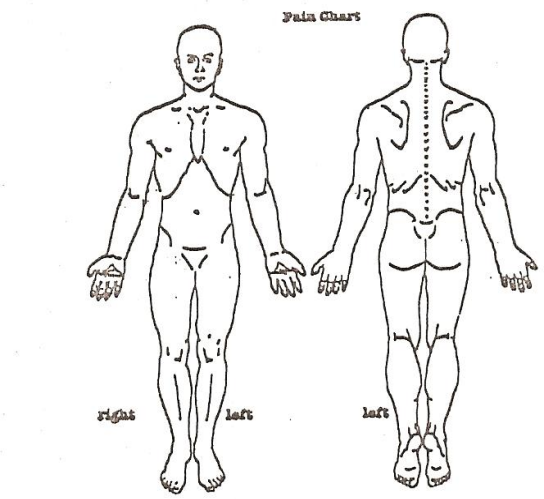
TYPE OF PAIN: dull achy throbbing spasms sharp stabbing burning numbing shooting cutting tingling pounding cramping constricting
PAIN FREQUENCY**:** up to ____25 % ____ 50% ____ 75% ____100%

MID BACK pain >>rib pain L/R>>chest pain>>difficulty breathing
0----1------2----3-----4------5------6------7------8-------9------10

TYPE OF PAIN: dull achy throbbing spasms sharp stabbing burning numbing shooting cutting tingling pounding cramping constricting
PAIN FREQUENCY**:** up to ____25% ____50% ____75% ____100%

LOWER BACK pain > >radiating L / R hip / leg / knee / ankle / foot
0----1------2----3-----4------5------6------7------8-------9------10

TYPE OF PAIN: dull achy throbbing spasms sharp stabbing burning numbing shooting cutting tingling cramping pounding constricting
PAIN FREQUENCY**:** up to ____25% ____50% _____75% ____100%



WORSE in the 1) morning 2) afternoon 3) evening 4) bedtime (choose only one)

Affect on your <u>ACTIVITY</u>? 1) None 2) Some affect 3) Seriously affect 4) Prevents activity

Activity affected: housework, yard work, personal care, sitting, standing, walking, bending, lifting, turning

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<u>Exam Findings</u>
Cervical _____Pain / edema // muscle-spasms / guarding / hypertonic // spinous // paravertebral musculature- L / R
*Range of motion: flex _____/50; ext_____/60; LLF____ /45; Lrot_____/80; Rrot_____/80 * * Cervical compression + L / R
Thoracic _____ Pain / edema // muscle-spasms / guarding / hypertonic // spinous // paravertebral musculature – L / R
Lumbar _____ Pain / edema // muscle-spasms / guarding / hypertonic // spinous // paravertebral musculature – L /R
*Range of motion: flex_____/60; ext_____/25; LLF_____/30; RLF_____/30;Lrot_____/30;Rrot_____/30
** Kemp +_____LB>_____leg // SLR_____ // Derefield L / R (+s/____) _____
Sacrum_____ sacral apex L / R _____ sacroiliac/pelvis L / R _____
Painful trigger points: occ____ // lv scp+trap _____ // psis ____ // glut _____ // knee _____ // Painful sciatic – notch / trace – L / R
<u>ASSESSMENT</u>: New patient exam detailed 99203-25 exp 99202-25 foc 99201 rx/exp 99213-25 rxfoc 99212-25 min 99211
Dx: **Cervical- 739.1***722.0 * 847.0 ** **Thoracic 739.2***722.1 * 847.1 ** **Lumbar 739.3***722.2 * 847.2 ** **SI** 846.1

<u>PLAN</u>: CASH WC NF ChiroPlan Ashn Hmsa/Blue Cross UHA Hmaa Union VA Tx Plan_____
_____97022 Whirlpool (15 min/unit) C / T / L
_____97012 Mechanical traction (15 min/unit) C / T / L **Medicare: AT GX GY GZ ABN DOI**_____
_____97039 Unlisted Modality (Unattended) (15 min/unit) C / T / L
_____97032 EMS (Attended) (15 min/unit): C / T / L (a) freq_____ s/_____p change to _____s/_____p (b) probe _____%
_____97041 Manual therapy __ Soft tissue mobilization (15 min/unit) C / T / L Myofascial release (15 min/unit) C / T / L
___Flex-distraction (15 min/unit) C / T / L __ Manual traction (15 min/unit) C / T / L
_____97110 __ Therapeutic exercises (15 minutes = 1 unit) __ Isokinetic exercise ____ C / T / L stabilization exercise 3x10

Spine manipulation: 98940 = 1-2 regions 98941= 3-4 regions 98942=5 regions
Spinal region Cranial_____C_____T_____L_____Sacral_____Pelvic_____
Treatment plan _____ D / 1 / 2 / 3 X per wk / mo // _____ wk // PRN Work status: reg / modified _____/ off _____
Refer to: Physical therapy // Massage // MRI * X-ray C*T*L // FCE-WCE // Voc rehab _____
Medical evaluation / Concurrent care / EMG testing / Nerve conduction velocity testing / neurosurgical evaluation
Other: pillow=E0943 / home traction C/L // support C / LB=L0515 / Ice pack / therapy ball / Nutrition _____
Response to today's treatment: ____ tolerated well // pain scale _____/rom_____/posture_____//same: _____better _____worse_____
Overall response to chiropractic care: ____Progressing as anticipated; ____Progressing slowly: ____Recurring
____up and down with symptoms; ____ Flare-up; ____ Aggravated by ADL's_____

** All treatment provided one on one by Dr. Alejandro Lazo, DC_____