WNY SPINAL SOLUTIONS REGISTRATION PAPERWORK

Name: _____ Date: _____

Social Security Number: _____ Date of Birth:_____

Address: _____ City: _____ Zip:_____

Cell: _____ Home Ph: _____

Occupation: _____ Employer: _____

Marital Status: _____ Children: Y / N Ages: _____

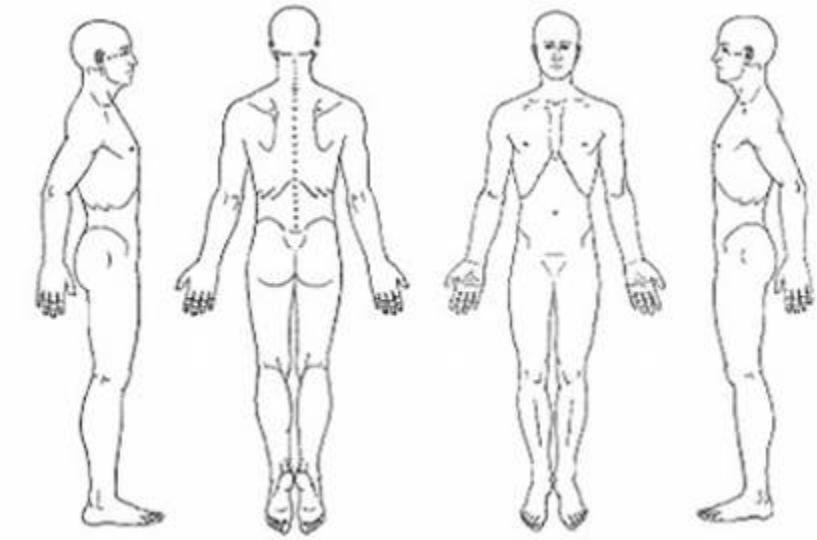
Email: _____Referred by: _____

PRESENT COMPLAINTS (Circle all that apply)

Headache
Mental Dullness
Loss of Memory
Dizzy
Fear
Pins/Needles in Arms/Hands
Pins/Needles in Legs/Feet
Depression
Nervousness

Upper back pain
Midback pain
Rib Pain
Shortness of breath
Loss of Smell/Taste
Confusion
Eye Strain/Pain
Neck Pain

Fainting
Blurry/Double Vision
Irritability
Ears Ringing/Buzzing
Unbalanced
Hands Cold
Chest Pain
Low back Pain



Please circle the areas where you have symptoms on the diagram to the left.
Use this key to describe your symptoms.

S=Sharp
A=Achy
D=Dull
N=Numb
T=Tingling
B=Burning

How constant are your symptoms?

Constant
Frequent
Intermittent
Occasional

Name: _____

Medications:

Please list all medications you currently take.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Supplements:

Please list all supplements you currently take.

_____ _____

_____ _____

_____ _____

_____ _____

Allergies:

_____ _____

_____ _____

Smoking:

_____ packs/day _____ years

Drinking:

_____ drinks/week

Sleep:

_____ hours/night

Meals/Day:

_____

Days of Exercise/Week:

_____

Type(s) of Exercise:

_____ _____

Amount of Water Consumed Daily:

_____ oz.

Stress Level: Low Moderate High

Name: _____

Surgical History:

Please list ALL previous surgeries and the dates performed.

_____ _____

_____ _____

_____ _____

_____ _____

Review of Systems:

Please indicate any medical problems that you currently have or had in the past.

LUNG:

Asthma	Pulmonary Embolism	Respiratory Arrest
COPD	Pneumonia	Sleep Apnea
Emphysema	Tuberculosis	
Other: _____		

CARDIAC:

Chest Pain/Angina	High Blood Pressure	Arrhythmia
Heart Attack	Murmur/Valve Disorder	Bleeding Problems
Peripheral Vascular Disease	Mitral Valve Prolapse	Congestive Heart Fail

NEURO:

Stroke/TIA	Multiple Sclerosis	Fibromyalgia
Peripheral Neuropathy	Cerebral Palsy	Polio
Parkinson's		
Other: _____		

BONE/JOINT:

Osteoarthritis	Osteomyelitis	Gout
Rheumatoid Arthritis	Ankylosing Spondylitis	Lupus
Other: _____		

GASTRO:

Ulcer	Diverticulitis	Hepatitis, Type _____
Acid Reflux	Irritable Bowel	Crohn's
GI Bleed	Celiac's	Ulcerative Colitis
Other: _____		

URINARY:

UTI	Kidney Stones	Incontinence
Kidney Failure/Dialysis	Other: _____	

Name: _____

METABOLIC/OTHER:

Diabetes, Type _____, _____ years	Depression	Anxiety
Hashimoto's Thyroiditis	Hypothyroidism	Hyperthyroidism
Grave's Disease	Sickle Cell Disease	Psoriasis
High Cholesterol	Tooth Abscess	Skin Ulcer
Alcohol/Drug Dependency	Cancer (please specify):_____	

Other: _____

_____

Family History: Please Indicate any significant family history and the affected member of your family (i.e. mother, paternal grandfather, etc)

COPD/Emphysema	Lupus
Heart Attack	Gout
Peripheral Neuropathy	Bowel Disease
Liver Disease	Hepatitis, Type _____
Kidney Failure	Sickle Cell Disease
Diabetes, Type _____	Stroke
Hypothyroid	High Cholesterol
Hyperthyroid	High Blood Pressure
Tuberculosis	Other Lung: _____
Congestive Heart Failure	Other Heart: _____
MS	Other Neuro:_____
Parkinson's	
Cancer: (please specify)	

_____

_____

Significant Trauma/Accidents:

_____ _____

_____ _____

_____ _____

Primary Care Physician (Name, Address, Phone Number)

_____

_____

_____

Name: _____

Informed Consent:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physio-therapy on me (or the patient named below, for who whom I am legally responsible) by SG Chiropractic Health Care, PC's doctors. All these licensed Doctors of Chiropractic have my consent to treat me, who now or in the future treat me while employed by, working, or associated with, or serving as backup for SG Chiropractic Health Care, PC, including those working at the clinic or office listed or any future office or clinic.

I have had an opportunity to discuss with the doctor named below and/or with other office/clinic personnel the nature and purpose of chiropractic adjustments or other procedures. I understand that results are not guaranteed. I understand that the doctor(s) do not offer to diagnose or treat any condition or disease other than vertebral subluxation, nor do they offer advice regarding treatment prescribed by others. However, if during a chiropractic examination, abnormal or unusual findings outside the scope of chiropractic are discovered, the doctor will advise me and make the most appropriate referral.

I understand I am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the procedure(s) which the doctor feels, at the time, based upon the facts then known, is in my best interests. I understand that all adjustments are made in the open suite and that if I require private consultation with the doctor, I can arrange that with the front desk staff at any time during normal office hours.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present conditions and for any future condition(s) for which I seek treatment.

Patient Signature _____Date: _____

Doctor Signature _____Date: _____

Authorization to Release Medical Records:

I authorize the release of any medical information necessary to process my case and/or insurance claim(s) and certify that all insurance information given to this clinic is correct and complete.

Patient Signature _____Date: _____

Assignment of Benefits:

I, the undersigned, have insurance coverage _____ and assign directly to SG Chiropractic Health Care, PC, all medical 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 my insurance submissions.

Patient Signature_____ Date: _____

Name: _____

SG Chiropractic Health Care's Notice of Privacy for: Patient's Protected Health Information

This notice describes how health information about you may be used, disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or the Worker's Compensation Board to verify that treatment has been rendered.
- To determine patient's benefits in a health care plan.
- Releasing information required by State and Federal Public Health Law
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurance for your privacy have been attained.
- Emergency situations
- Abuse, neglect or domestic violence
- Appointment reminders to household members or answering machines
- Sign-in logs may be disclosed to verify office visits.

Any other uses or disclosures will only be made with your specific written prior authorization.

You have the right to:

- Revoke authorization, in writing, at any time, by specifying what you want restricted and to whom.
- Speak to our privacy officer, Marne Griffin, who can be reached at 716-675-5776 regarding privacy issues.
- Inspect, copy and amend your PHI
- Obtain our accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer or the Secretary of Health and Human Services

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information it maintains. Patients may also get an updated copy at any time by asking the staff. (Last Amended: 6/20/2016)

I acknowledge that I have received and reviewed this notice with full understanding.

Patient Signature _____ Date _____