CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Date: _____

Social Security # _____

Patient Name:

_____
Last Name First Name Middle Initial

Address: _____
Street/P.O. Box

City _____

State _____ Zip _____

Sex ☐ Female ☐ Male Age: ____

Birth Date: _____

Marital Statues ☐ Married ☐ Single ☐ Widowed
☐ Separated ☐ Divorced ☐ Minor

Patients Employer/School _____

Occupation _____

Whom may we thank for referring you?

_____

PHONE NUMBERS

EMAIL _____

Cell Phone _____ Home Phone _____

Best time and Place to reach you _____

Emergency Contact:

_____

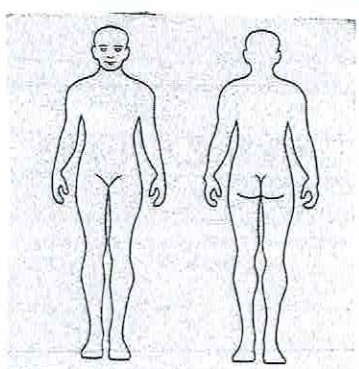
Cell # _____ Home # _____

PATIENT CONDITION

Reason for Visit _____
When did your symptoms appear? _____
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 ☐ Other

How often do you have this pain? _____
Is it constant or does it come and go ? _____
Does it interfere with you ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities or movements that are painful to perform
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



INSURANCE INFORMATION

Who is responsible for this account? _____

Is patient covered by insurance? _____

Primary Insurance

Subscriber's Name: _____

Birth Date: _____ SS# _____

Insurance Company: _____
Policy # _____ Group # _____

Is Patient covered by additional insurance? Yes No

Secondary Insurance

Subscriber's Name: _____

Insurance Company: _____
Policy # _____ *Group #* _____

ASSIGNMENT AND RELEASE
I Certify that I, and/or my dependent(s), have insurance coverage with the above named company (ies) and assign directly to Dr. James Vigil, D.C. 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.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Patient Signature Date

ACCIDENT INFORMATION

Is your 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

Attorney Name (if applicable) _____

Do you currently or have you had: Please mark all that apply

	Current	Past
Sleep Problems	☐	☐
Disabled	☐	☐
Nervous tension	☐	☐
Irritability	☐	☐
Mood Swings / changes	☐	☐

Do you currently or have you had: Please mark all that apply.

	Current	Past
Growing moles or lumps	☐	☐
Wear glasses or contacts	☐	☐
Glaucoma	☐	☐
Light bothers eyes	☐	☐
Other eye problems	☐	☐

Date of last eye exam: _____

Hearing difficulties	☐	☐
Ringing in ears	☐	☐
Sinus infection	☐	☐
Motion sickness	☐	☐
Dental Problems	☐	☐

Date of last dental exam: _____

Do you currently or have you had: Please mark all that apply.

	Current	Past
More frequent urination	☐	☐
Pain or blood with urination	☐	☐
Leaking urine	☐	☐
Urinating at night	☐	☐
Kidney or bladder infection	☐	☐
Kidney stones	☐	☐
Recurrent abdominal pain	☐	☐
Ulcers	☐	☐
Heartburn	☐	☐
Swallowing problems	☐	☐
Hernia	☐	☐
Hemorrhoids	☐	☐
Polyps	☐	☐
Loss of smell	☐	☐

Do you currently or have you had: Please mark all that apply.

	Current	Past
Arthritis or gout	☐	☐
Bursitis	☐	☐
Fractured bones	☐	☐
Seizures	☐	☐
Tremor	☐	☐
Passing out	☐	☐
Speech problems	☐	☐
Trouble concentrating	☐	☐
Diarrhea or constipation	☐	☐
Varicose veins	☐	☐

Patient Name _____

Do you currently or have you had: Please mark all that apply

	Current	Past
Asthma	☐	☐
Eczema	☐	☐
Hay Fever	☐	☐
Sinus Problems	☐	☐
Diabetes	☐	☐
High cholesterol or triglycerides	☐	☐
Thyroid trouble	☐	☐
Liver trouble	☐	☐
Anemia	☐	☐
Bleeding or bruising tendency	☐	☐

Do you currently or have you have: Please mark all that apply:

	Current	Past
Low blood pressure	☐	☐
Racing, pounding heart	☐	☐
Ankle swelling	☐	☐
Lung or breathing problems	☐	☐
Pneumonia	☐	☐

Do you currently or have you had: Please mark all that apply:

	Current	Past
History of trauma	☐	☐
Infection	☐	☐
Unexplained weight loss	☐	☐
Unusual fatigue	☐	☐
Dizziness / Poor balance	☐	☐
Vomited blood	☐	☐
Bloody or black stools	☐	☐
Change in appetite	☐	☐
Fevers	☐	☐
Night Sweats	☐	☐
High blood pressure	☐	☐
Chest Pain	☐	☐
Shortness of breath	☐	☐
Chronic cough	☐	☐
Stroke	☐	☐
Heart disease or murmur	☐	☐
Loss of bowel or bladder control	☐	☐
Headaches	☐	☐
Muscle weakness or paralysis	☐	☐
Memory loss	☐	☐
Severe trauma	☐	☐
Direct head trauma	☐	☐
Lost consciousness	☐	☐
Poor coordination	☐	☐
Night pain	☐	☐
Difficulty Swallowing	☐	☐
Recent infection	☐	☐
History of osteoporosis	☐	☐
History of cancer	☐	☐
Difficulty breathing	☐	☐
Abdominal pain	☐	☐
Use of corticosteroids	☐	☐
Use of anticoagulants	☐	☐
Use of birth control pills	☐	☐
Numbness in groin (saddle anesthesia)	☐	☐
Loss of anal sphincter tone, fecal incontinence (bowel accidents)	☐	☐
Pain fails to improve with rest	☐	☐
Pain greater than 4 weeks	☐	☐
Prolonged use of corticosteroids	☐	☐
Intravenous drug use	☐	☐

TESTS: Please list the MOST recent date:

Chest X-ray _____ EKG _____ Other X-ray _____ MRI/CT Scans _____

HABITS:	YES	NO	If yes, please describe:
Smoking	☐	☐	Packs per day: 0 – ½ ☐ ½ - 1 ☐ 2 or more ☐ Duration _____
Alcohol Consumption	☐	☐	# Drinks per day _____ Drinks per week _____
Coffee or Tea Consumption	☐	☐	Cups per day _____
Other Drug Use (Street Drugs)	☐	☐	_____
Exercise	☐	☐	Daily ☐ Weekly ☐ Monthly ☐ Type _____

HOBBIES OR INTEREST: _____

MEDICINES: Please list all currently used medicines. Include prescription and non-prescription drugs, vitamins, herbs

_____

ALLERGIES: Please list all known allergies, especially to medicines. _____

Treatment you are receiving or have received:

Medical care ☐ Chiropractic care ☐ Other ☐ _____

Are you: Right handed ☐ Left handed ☐ Ambidextrous ☐

Do you currently or in the past have: Please mark all that apply

	Currently	Past (When, #episodes
Back pain or stiffness	☐	☐
Neck pain or stiffness	☐	☐
Shoulder pain	☐	☐
Hip pain	☐	☐
Foot pain or trouble	☐	☐
Swollen or painful joints	☐	☐
Cold hands or feet	☐	☐
Numbness or pain in the arms, hands or fingers	☐	☐
Numbness or pain in the legs, feet or toes	☐	☐

MALES ONLY

Do you have:

☐ Changes in urine stream ☐ Prostate trouble

☐ Lumps in testicles ☐ Sex concerns

Date of last prostate exam: _____

FEMALES ONLY

Do you have:

☐ Menstrual problems ☐ Vaginal discharge

☐ Abnormal bleeding ☐ Tubal infections

☐ Breast lumps or pain ☐ Sex concerns

☐ Problems getting pregnant

Age periods began: _____

Number of pregnancies: _____

Number of miscarriages or abortions: _____

Number of Cesarean Sections: _____

Type of birth control: _____

Date of last gynecological exam: _____

Date last period began: _____

Are you currently or possibly pregnant? _____

In general, how would you rate your health? ☐ **Excellent** ☐ **Average** ☐ **Poor**

Do you feel depressed or have trouble falling asleep, poor appetite, lack of interest in normally enjoyable activities, relationship problems? ☐**No,** ☐ **Yes If yes, please explain:** _____

_____

DOCTOR'S NOTES: _____

_____

_____

Patient Name: _____ **Date:** _____

ABOUT YOUR FAMILYHISTORY:

Please mark relative's current age or age at time of death, place an X in the boxes that apply to them. Describe "Other" and list cause of death

	Age	Allergy – Asthma	Alcohol Abuse	Arthritis – Gout	Bleeding Disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	Heart Disease	High Blood Pressure	Kidney Disease	Psychiatric Problems	Spine or back disorder	Stroke	Tuberculosis	Chronic Pain	Other	If deceased, cause of death
Mother's Mother																				
Mother's Father																				
Father's Mother																				
Father's Father																				
Father																				
Mother																				
Brother's & Sisters #1																				
#2																				
#3																				
#4																				
#5																				
Spouse																				
Children #1																				
#2																				
#3																				
#4																				
#5																				

HOSPITALIZATIONS, OPERATIONS, AUTO ACCIDENT or WORK INJURIES (Please be as specific as possible)

AREAS INVOLVED INDICATE EVALUATIONS & TREATMENT

Year

1.
2.
3.
4.
5.
6.
7.

SERIOUS ILLNESSES: List current and past illnesses not mentioned above. (Including cancer, diabetes, etc.)

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

Patient Name: _____

Date: _____

Patient Name: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

110 E. 6th Street
719-738-3808

Walsenburg, CO 81089
fax 719-738-3808

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I Hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, costovertebral strains and separations, muscle strains, or reaction to a modality. 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. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, and are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Name and address of Office or Clinic:

Vigil Family Chiropractic
110 East 6th Street
Walsenburg, CO 81089

Names of Doctors treating this patient:

James T. Vigil, D.C.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

_____
Printed Name of Patient

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Guardian Date

_____ _____
Witness to Patient's Signature Date