# Registration Form

## PERSONAL INFORMATION

Name: Date: / /

Address: Home Phone:

 Cell Phone:

Cellular Provider Work Phone:

Social Security # Birth Date: / /

Please circle one: Male / Female Married / Single / Widowed / Divorced

How did you hear about us?

Email Address: Work Email:

Other family member’s names:

## INSURANCE INFORMATION

**(Please give your insurance card and driver’s license to the front desk for a complimentary benefit check)**

Primary Insurance Carrier: Subscriber’s Name:

Occupation: Employer:

Subscriber’s S.S. # Birth Date: / /

**Insurance Policies and Fee Schedules**

* **Consultation-**includes practice member history. This service is complimentary.
* **Examination (new patient or established patient)-**includes one of more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check.
* **Chiropractic Adjustment –** The actual re-alignment of the vertebra. A specific instrument is used to make the spinal adjustment. 1 to 3 specific adjustments will be made per visit, re-aligning the vertebra.
* **X-rays –** Specific x-ray views taken of your spine to determine a misalignment/subluxations of your vertebrae. These can also be used to indicate progress after period of care.

**Release of Authorization/Assignment of Benefits**

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of insurance benefits directly to Joseph Smola, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other Arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed Date



Dr. Joseph Smola

Dynamic Health Chiropractic

48000 Grand River Ave.

Novi, Michigan 48374

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely.

Who can we thank for referring you here today? Have you ever been to a Chiropractor before? Y / N

On a scale of 1-10, rate your commitment in helping us solve your health issues: [0 1 2 3 4 5 6 7 8 9 10 ]

## HEALTH CONCERNS:

**Health Concerns:**

**In Order of Importance**

**Severity How long have Did this start**

**1=Mild you had this? with an 10=Unbearable injury?**

**Have you**

**had this before?**

**Is this constant**

**or comes/goes?**



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How do your health concerns affect your daily living (brushing teeth, getting dressed, work, etc.)?

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Please mark “P” for in the Past, OR mark “C” for Currently have:

\_\_\_ Headaches \_\_\_ Ear Infections \_\_\_ Sinus Issues \_\_\_ Kidney Problems \_\_\_ Sexual Dysfunction

\_\_\_ Migraines \_\_\_ Hearing Loss \_\_\_ Frequent Colds\_\_\_ Bladder Problems \_\_\_ Sleep Problems

\_\_\_ Jaw/TMJ Pain \_\_\_ Ringing in the Ears \_\_\_ Thyroid Issues \_\_\_ Menstrual Problems \_\_\_ Tight/Sore Muscles

\_\_\_ Neck Pain \_\_\_ Dizziness \_\_\_ Asthma \_\_\_ Prostate Problems \_\_\_ GERD/Gastric Reflux

\_\_\_ Shoulder Pain \_\_\_ Loss of Energy \_\_\_ Chest Pain \_\_\_ Infertility \_\_\_ Upper Back Pain

\_\_\_ Arm Pain \_\_\_ Nervousness \_\_\_ Fibromyalgia \_\_\_ Arthritis/Joint Pain \_\_\_ Heart Problems

\_\_\_ Nausea \_\_\_ Sports Injury \_\_\_ Disc Problems \_\_\_ Double/Blurry Vision \_\_\_ Lower Back Pain

\_\_\_ Sciatica \_\_\_ Anxiety \_\_\_ Ulcers \_\_\_ Tremors \_\_\_ Mid Back Pain

\_\_\_ Skin Problems \_\_\_ Epilepsy/Convulsions \_\_\_ Difficulty Breathing

\_\_\_ ADD/ADHD \_\_\_ Digestive Issues \_\_\_ Allergies \_\_\_ Foot Pain \_\_\_ Bed Wetting

\_\_\_ Hip/Leg Pain \_\_\_ Loss of Balance \_\_\_ Diarrhea \_\_\_ Scoliosis \_\_\_ Stomach Problems

\_\_\_ Knee Pain \_\_\_ Depression \_\_\_ Constipation \_\_\_ Poor Posture \_\_\_ High/Low Blood Pressure

 \_\_\_ Numb/Tingling in Arms/Hands \_\_\_ Numb/Tingling in Legs/Feet

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please mark “P” for in the Past, OR mark “C” for Currently have:

\_\_\_STROKE \_\_\_ CANCER \_\_\_HEART ATTACK \_\_\_SPINAL SURGERY \_\_\_SEIZURES

\_\_\_SPINAL BONE FRACTURE \_\_\_SCOLIOSIS \_\_\_DIABETES \_\_\_OSTEOARTHRITIS \_\_\_RHEUMATOID ARTHRITIS

\_\_\_OTHER CONDITIONS/DISEASES

## MAIN COMPLAINT HISTORY:

1. How would you describe the pain?

Sharp Soreness Throbbing Tingling Dull Stiffness Spasm Burning Ache Weakness Numbness Shooting

1. Does the pain travel anywhere else? Yes No Describe:
2. How often is this present?

Constant (81 – 100%) Frequent (51 – 80%) Occasional (26 – 50%) Intermittent (25% or less)

1. Since it started, has the pain gotten better, worse or stayed the same?
2. What makes your complaint worse?

Nothing Walking Standing Sitting Exercise (Moving) Lying Down Other If other, please explain:

1. Have you seen anyone else for this health concern? (Medical Doctor, Chiropractor, etc.) If so, who?

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1. Please list all medications you are taking and for what:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Please list any broken bones, surgeries or hospitalizations you have had and when:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Please list any auto accidents or injuries you have been involved in:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please check off any of the conditions below that you (or your family) have or have had in the past:

**-** Write **C** if **Current** issue or **P** if **Past** (Resolved) issue*. If P, provide estimate date of last occurrence*



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yourself** | **Spouse** | **Children** | **Mother** | **Father** |
| Asthma |  |  |  |  |  |
| Arthritis |  |  |  |  |  |
| TMJ |  |  |  |  |  |
| Acid Reflux |  |  |  |  |  |
| Epilepsy |  |  |  |  |  |
| Ulcers |  |  |  |  |  |
| Dizziness |  |  |  |  |  |
| Headaches |  |  |  |  |  |
| Vertigo |  |  |  |  |  |
| Nervousness |  |  |  |  |  |
| Menstrual Irregularity |  |  |  |  |  |
| Nausea |  |  |  |  |  |
| Lupus |  |  |  |  |  |
| Fatigue |  |  |  |  |  |
| Numbness |  |  |  |  |  |
| Ear Infections |  |  |  |  |  |
| Sciatica |  |  |  |  |  |
| Cardiac Condition |  |  |  |  |  |
| Migraines |  |  |  |  |  |
| Sinus |  |  |  |  |  |
| Kidney Condition |  |  |  |  |  |
| Liver Disease |  |  |  |  |  |
| Fainting |  |  |  |  |  |
| Disc Problems |  |  |  |  |  |
| Stiffness |  |  |  |  |  |
| Irritable Bowel |  |  |  |  |  |
| Stomach Condition |  |  |  |  |  |

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**ADJUSTMENT:** An adjustment is the specific application of forces to facilitate the body’s correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine.

**HEALTH:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**VERTEBRAL SUBLUXATION:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body’s innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body’s innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, have read and fully understand the above statements.

All questions regarding the doctor’s objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature Date

# Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician’s certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Signature Date

**X-Ray Authorization**

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF THE X-RAYS IN OUR FILES.

**PLEASE NOTE:** X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF DYNAMIC HEALTH CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

##  BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS

PRINTED NAME: DATE:

SIGNATURE: YOUR AGE:

**FEMALE PATIENTS ONLY**: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT DYNAMIC HEALTH CHIROPRACTIC OF

SIGNATURE DATE

**DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE**

|  |  |  |  |
| --- | --- | --- | --- |
| D Lat Cervical D Flex/Ext | D Lower Cervical | D Lateral Thoracic | D A-P Thoracic |
| CM Kvp Time MAS | CM Kvp Time MAS | CM Kvp Time MAS | CM Kvp Time MAS |
| D10-11 D78 D1/24 12.5 | D14-15 D70 D1/10 20 | D22-23 D80 D1/15 20 | D16-17 D75 D1/20 17 |
| D12-13 D D1/20 15 | D16-17 D D2/15 30 | D24-25 D D1/10 30 | D18-19 D D1/15 22 |
| D14-15 D1/15 20 | D18-19 D3/20 40 | D26-27 D2/15 40 | D20-21 D1/10 30 |
| D16-17 D1/10 30 | D20-21 D2/10 50 | D28-29 D2/10 50 | D22-23 D2/15 40 |
| D2/15 40 | D22-23 | D30-31 D1/4 75 | D24-25 D2/10 50 |
| MA 300 Size 8x10 | MA 300 Size 8x10 | D32-33 D3/10 90 | D26-27 D1/4 75 |
|  |  | D34-35 D2/5 120D36-37 D1/2 150 | D28-29 D3/10 90D30-31 D2/5 120 |
| D APOMCM Kvp Time MAS | OtherView  |
| D14-15 D70 D1/10 20D16-17 D D2/15 30D18-19 D3/20 40D20-21 D2/10 50 | CM Kvp MAS MA  | MA 300 Size14x17 | MA 300 Size14x17 |
| D Lateral LumbarCM Kvp Time MASD26-27 D88 D2/10 30 | D A-P LumbarCM Kvp Time MASD20-21 D76 D1/15 40 |
| D22-23MA 300 Size 8x10 | Size  | D28-29 D90 D1/4 40D30-31 D92 D3/10 50 | D22-23 D78 D1/10 50D24-25 D80 D2/15 75 |
| Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| D32-33 D94 D2/5 70 | D26-27 D D2/10 90 |
| D34-35 D96 D1/2 90 | D28-29 D1/4 120 |
| D36-37 D D3/5 120 | D30-31 D3/10 150 |
| D38-39 D4/5 160 | D32-33 D2/5 120 |
| D40-41 D1 200 | D34-35 D1/2 170 |
| D42-43 D1 1/2 | D36-37 D3/5 210 |
| D2 | D38-39 D4/5 |
| MA 200 Size 14x17 | D40-41 D1 |
| **CA Initials:**  | D42-43 D1 1/2 |
| D2 |
| MA 300 Size 14x17 |

**QUADRUPLE VISUAL ANALOGUE SCALE (QVAS)**

Please **circle** the number that best describes the question asked. If you have more t**h**an one complaint, please answer each question for each individuation complain and indicate the score of each complaint.

EXAMPLE:

No pain Worst possible pain 0 1 2 3 4 5 6 7 8 9 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

1. What is your TYPICAL or AVERAGE pain?



0 1 2 3 4 5 6 7 8 9 10

1. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain its best? %

1. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain its worst? %

Practice Member Name: Date:

Score: Q1 +Q2 +Q4 = /3x10= (Low Intensity = <50; High Intensity = >50)