

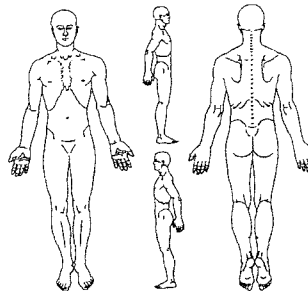


PATIENT REGISTRATION FORM

NAME			HOME #		
ADDRESS			WORK #		
CITY-STATE-ZIP			FAX #		
EMERGENCY CONTACT		PHONE #	SS #		E-MAIL
<input type="radio"/> MALE <input type="radio"/> FEMALE	<input type="radio"/> S <input type="radio"/> M <input type="radio"/> D <input type="radio"/> W	DATE OF BIRTH		DRIVER LICENSE #	
EMPLOYER			OCCUPATION		
ADDRESS			CITY-STATE-ZIP		
REFERRED BY			PRIVATE PHYSICIAN		

PLEASE INDICATE REGION OF COMPLAINT

<input type="radio"/> HEADACHE PAIN
<input type="radio"/> NECK PAIN
<input type="radio"/> UPPER/MID BACK PAIN
<input type="radio"/> LOW BACK PAIN
<input type="radio"/> SHOULDER-ELBOW-WRIST-HAND PAIN
<input type="radio"/> HIP-KNEE-ANKLE-FOOT PAIN
<input type="radio"/> OTHER



USE THE LETTERS LISTED BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR PAIN AND SENSATIONS...

KEY

- A = ACHE
- B = BURNING
- S = STABBING
- N = NUMBNESS
- P = PINS & NEEDLES
- O = OTHER

MEDICAL HISTORY

	YES	NO	
<input type="checkbox"/> ARTHRITIC CONDITION	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> LIST MEDICATIONS
<input type="checkbox"/> CANCER	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> DIABETES	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> HEART PROBLEMS	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> ALLERGIC TO MEDICATIONS
<input type="checkbox"/> VASCULAR CONDITION	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> LUNG PROBLEMS	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> USUAL CHILDHOOD DISEASES	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> ALLERGIES
<input type="checkbox"/> UNUSUAL CHILDHOOD DISEASES	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> CURRENTLY PREGNANT	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> EXERCISE REGULARLY	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> HEIGHT
<input type="checkbox"/> SMOKER	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> WEIGHT
<input type="checkbox"/> ALCOHOL	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> LIST SURGERIES / HOSPITALIZATIONS
<input type="checkbox"/> ALLERGIES	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> BIRTH CONTROL MEDICATIONS	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> OTHER			

SPECIFIC INJURY? <input type="radio"/> YES <input type="radio"/> NO	DATE OF INJURY
PREVIOUS TREATMENT? <input type="radio"/> YES <input type="radio"/> NO	TREATMENT TYPE
DOCTOR NAME	PHONE #
NATURE OF INJURY <input type="radio"/> AUTO <input type="radio"/> WORK RELATED <input type="radio"/> HOME / OTHER	COMPLETE SECTIONS 1 & 3 ONLY COMPLETE SECTIONS 2 & 3 ONLY COMPLETE SECTION 3 ONLY

SECTION #1 - PERSONAL INJURY

DATE	TIME	<input type="radio"/> AM	<input type="radio"/> PM	LOCATION OF ACCIDENT
<input type="radio"/> AUTO V AUTO	<input type="radio"/> AUTO V TRUCK	<input type="radio"/> MOTORCYCLE		<input type="radio"/> AUTO V BUS
<input type="radio"/> AUTO V PEDESTRIAN	<input type="radio"/> SLIP & FALL	<input type="radio"/> OTHER		
PLEASE DESCRIBE INJURY				
<input type="radio"/> DRIVER OR <input type="radio"/> PASSENGER	<input type="radio"/> FRONT SEAT OR <input type="radio"/> BACK SEAT	WEARING SEAT BELT OR SHOULDER HARNESS?	<input type="radio"/> YES	<input type="radio"/> NO
BODY PARTS STRUCK	<input type="radio"/> YES <input type="radio"/> NO	IF YES, PLEASE LIST		
EMERGENCY TREATMENT?	<input type="radio"/> YES <input type="radio"/> NO	IF YES, WHERE?		
WORK -RELATED?	<input type="radio"/> YES <input type="radio"/> NO	IF YES, ANY WORK LOSS?	<input type="radio"/> YES	<input type="radio"/> NO
LOSS OF CONSCIOUSNESS?	<input type="radio"/> YES <input type="radio"/> NO	WERE YOU BLEEDING?	<input type="radio"/> YES	<input type="radio"/> NO
X -RAY TAKEN?	<input type="radio"/> YES <input type="radio"/> NO	IF YES, LIST AREAS		

SECTION #2 -WORKERS' COMPENSATION INJURY / EMPLOYER INFORMATION

COMPANY NAME			
ADDRESS			
CITY-STATE-ZIP			
TYPE OF BUSINESS			
OCCUPATION			
DATE OF INJURY	TIME OF INJURY	<input type="radio"/> AM / <input type="radio"/> PM	DATE LAST WORKED
DESCRIBE INJURY			
INJURED AT [LOCATION-STREET-CITY-STATE-ZIP]			

SECTION #3 - INSURANCE INFORMATION / METHOD OF PAYMENT

<input type="radio"/> CASH	<input type="radio"/> CHECK	<input type="radio"/> GENERAL HEALTH INSURANCE	<input type="radio"/> WORKERS' COMPENSATION INSURANCE	<input type="radio"/> AUTO INSURANCE
INSURANCE COMPANY			CLAIM REPRESENTATIVE	
POLICY #	GROUP #	CLAIM #		
ADDRESS				
CITY-STATE-ZIP			PHONE #	
NAME OF INSURED			SS #	<input type="radio"/> SELF <input type="radio"/> OTHER
AUTO MED -PAY INSURANCE COMPANY			POLICY #	

AUTHORIZATION TO RELEASE MEDICAL INFORMATION / FINANCIAL AGREEMENT

I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION REQUESTED BY MY INSURANCE COMPANY TO DOCUMENT MY CLAIM FOR BENEFITS. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR FULL PAYMENT OF ALL CHARGES FOR MY TREATMENT. SERVICES ARE PAYABLE AT THE TIME RENDERED.

PATIENT OR GUARDIAN SIGNATURE

DATE

Activities Discomfort Scale

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

Activity	Doesn't Hurt At All	Hurts A Little	Hurts Very Much	Almost Unbearable	Unbearable Pain Prevents Activity
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running or jogging					
8. Climbing Stairs					
9. Carrying					
10. Pushing or Pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household Chores					
16. Gardening					
17. Sports					
18. Employment					

ADDITIONAL COMMENTS:

PATIENT NAME _____ PATIENT SIGNATURE _____

EXAMINER _____ DATE _____ Score _____ [72]

GUARINO CHIROPRACTIC
858 JORALEMON STREET
BELLEVILLE, NEW JERSEY 07109

INFORMED CONSENT

In the course of chiropractic health care, it is essential for the physician and patient to work towards the same objective. As a patient, you should understand the goal and methods of chiropractic that will be used in order to avoid confusion or disappointment.

Adjustment:

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health:

A state of optimal physical, mental and social well-being, not just the absence of infirmity.

Vertebral Subluxation:

A misalignment of one or more of the 24 vertebrae in the spinal column (which causes alteration of nerve function and interference to the transmission of mental impulses), which can impair the body's ability to achieve maximum health potential.

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

We do not 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 adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

(Signature)

(Date)