REISTER FAMILY CHIROPRACTIC
With Dr. J, well adjusted you will stay.
14050 Fruit Ridge Ave, Kent City, MI 49330
616-678-5538 Office 616-678-5320 Fax

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage our health expression. Following your exam & x-rays, your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

About Your Care

Chiropractic provides three types of care. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage. Then begins **Reconstructive Care** which corrects the years of damage. Finally, Chiropractic offers genuine **Wellness Care**.

Patient Information

Date: _____ **Name**: _____ **DOB**: _____ **Gender**: □ Male □ Female

Age: _____ **E-mail**: _____ **Marital Status**: S M D W

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Cell Phone**: _____ **Work Phone**: _____

Occupation: _____ **Employer** _____

Spouse's Name: _____ & **Occupation**: _____ **# of Children & Ages**: _____

Have you ever received Chiropractic Care? □ Yes □ No If so, with whom?_____

Approx. date of last adjustment _____ If you were referred, by whom? _____

Have you ever been in an accident? □ Yes □ No Type? □ Work □ Auto □ Other: _____ If Yes, when?_____

Did you require post-accident hospitalization? □ Yes □ No If so, Where? _____ When? _____

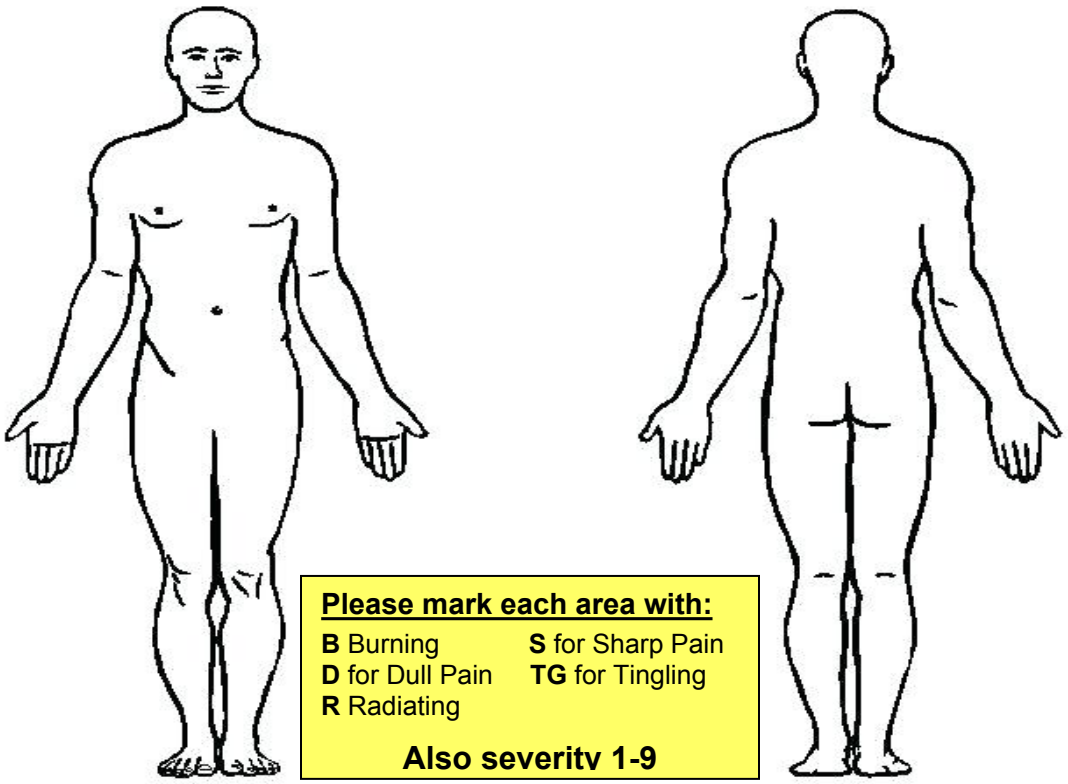
Were X-rays taken? □ Yes □ No Did you lose days at work as a result? □ Yes □ No How Many? _____

Is/Was insurance involved? □ Yes □ No If so, which company? _____

Attorney's name: □ N/A _____ Claim #: _____

Adjuster's Name _____ Adjuster's Phone # _____

Areas of Injury and/or Pain, Discomfort, Tenderness, Tingling



Listings

DEEP TENDON REFLEXES

	E1 L	E1 R
Biceps		
Brachio (C6)		
Patellar (L4)		
Achilles (S1)		

Cervical	
Rot	
Lat	
Flx Ex	

Lumbar	
Flex	
Ext	
Lat	
Rot	

C1 2 3 4 5 6 7	L / R
T1 2 3 4 5 6 7 8 9 10 11 12	L / R
L1 2 3 4 5	L / R

Present Complaint:

Major complaint:_____

Pain or Problem started when: _____ Is condition getting progressively worse? □ Yes □ No

Describe your pain: □ Burning □ Sharp □ Dull □ Ache □ Constant □ Intermittent

What caused it? _____

What activities aggravate your condition/pain? _____

Is condition worse during certain times of the day? □ Yes □ No If so, when?_____

Is this condition interfering with (check those that apply): □ Work □ Sleep □ Routine □ Other_____

What relieves it? _____

Has patient ever had same or similar condition/symptoms previous to this most recent occurrence? □ Yes □ No

Any home remedies used? □ Yes □ No If so, what?_____

Have you been under any drug and medical care? □ Yes □ No If yes, please explain: _____

_____

Please list medications you are currently taking: _____

Patient History

Have you had surgery □ Yes □ No

If yes, please list the date and type:

_____
_____
_____
_____
_____

What side effects (if any) did you experience from the drugs and/or surgery? _____

_____

Family History

Father's Side	**Mother's Side**
□ Heart Disease	□ Heart Disease
□ Arthritis	□ Arthritis
□ Cancer	□ Cancer
□ Diabetes	□ Diabetes
□ Other:_____	□ Other:_____

Symptoms and Ill Health (Present State of Ill Health-Past 12 Months)

Years of untreated damage showed up as acute or chronic symptoms

***Other* Symptoms**

□ Burning muscle pain	□ Chest pain/rib pain	□ Cold Sweats	□ Depression
□ Difficulty swallowing	□ Face Flushed	□ Fainting	□ Fatigue
□ Fever	□ Jaw pain	□ Nervousness	□ Sharp/shooting pain
□ Shortness of Breath	□ Sleeping Problems	□ Tension	
□ Back Pain	□ Constipation	□ Diarrhea	□ Erectile Dysfunction
□ Feet Cold	□ Loss of strength-legs	□ Numbness in legs/feet	□ Pain in legs/feet
□ Stomach Upset	□Tingling in legs/feet		
□ Buzzing in Ears	□ Clumsiness	□ Dizziness	□ Ears Ring
□ Headache	□ Irritability	□ Light Bothers Eyes	□ Loss of Balance
□ Loss of Memory	□ Loss of Smell	□ Nausea	
□ Hands Cold	□ Loss of strength-arms	□ Neck Pain	□ Neck Stiff
□ Numbness in arms/hands	□ Pain in arms/hands	□ Tingling in arms/hands	

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Consent for Purpose of Treatment, Payment and Healthcare Operations (HIPPA)

Regarding the Use & Disclosure of Health Information

I acknowledge that **Reister Family Chiropractic** "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Reister Family Chiropractic Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Reister Family Chiropractic. The Notice of Reister Family Chiropractic is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Reister Family Chiropractic duties with respect to my protected health information.

Reister Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

PATIENT ACKNOWLEGEMENT

By signing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Signature: _____ Date: _____

Print Name: _____

Name: _____ Relation/Authority: _____
(If personal representative used)

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CONSENT FOR RADIOLOGY

I, _____ give the doctors of Reister Family Chiropractic, my consent to take any and all x-rays needed to better understand my condition. I have been fully informed of the possible risks and safety standards of the office.

I also give my consent for films of my child/children for the same reasons, if applicable.

FOR LADIES ONLY:

To my best knowledge, I am not pregnant and know of no contraindications for x-ray at this time.

_____ _____

Patient signature **Date**

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TERMS OF ACCEPTANCE

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

Chiropractic has only one goal. It is important to 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 force to facilitate the body's correction of a subluxation, restoring proper biomechanics. Our chiropractic method of correction is by specific adjustment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column. Which cause alteration of nerve functions and interference to the transmission of 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 subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

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 interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct subluxation. No adjustment/treatment guarantees the desired result.

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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 _____

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ASSIGNMENT OF BENEFITS

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic to the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward and total charges for professional services rendered by this clinic.

_____ _____
Patient Signature Date

RELEASE OF INFORMATION

I authorize this clinic to release any information pertinent to my case to my insurance company, adjustor and attorney involved in this case and hereby release this clinic of any consequence there of.

_____ _____
Patient Signature Date

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment, and any services rejected by my insurance company.

_____ _____
Patient Signature Date

* **Medicare/Medicaid patients:**
We need your **Social Security Number** for Billing/Insurance purposes.

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EMERGENCY CONTACT SHEET

Patient's Name _____

Primary Contact:

Name _____ **Relationship** _____

Address _____

_____

Phone _____

Secondary Contact:

Name _____ **Relationship** _____

Address _____

_____

Phone _____