Coulter Chiropractic
REGISTRATION FORM

Date ______________ Home Phone ________________________ Cell Phone _______________________

Email ____

Last Name ________________________ First Name ________________________ Middle Initial _______

Street Address ____

City _____________________________ State ___________ Zip ____________

Sex: ▢M ▢F Age ________ Birth Date ______________ Occupation ______________________

Are you: ▢ Single ▢ Married ▢ Widowed ▢ Separated ▢ Divorced

Who referred you to this office? ____

PARENTAL CONSENT TO EVALUATE AND TREAT A MINOR

I __________________________, being the parent/legal guardian of _______________________ hereby grant permission for my child to receive chiropractic care. Witness ____________________

INFORMED CONSENT TO TREATMENT

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic adjustment and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as “rare” and the probability of adverse reaction due to ancillary procedures is also considered “rare”.

I wish to initiate care at this office. I have read and understand the Consent to Initiate Care and agree to all terms. I understand that I am under no obligation to receive or continue care.

Print your name ____ Today’s Date ________________

Sign your name ____

Coulter Chiropractic
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Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the privacy practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his or her Protected Health Information for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I, ___________________________________(print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my health information in accordance with it.

Print your name ___________________________________

Sign your name ___________________________________

Today's Date _________________

Patient Primary Complaint Form

Name: ________________________________ Date: ________________

What is the number one thing that bothers you the most today? _________

____

____

How did your pain begin? ______________________________________

Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Is your condition: Getting Better or Getting worse

Is your condition: On & Off or Constant

Type of Pain: Sharp Stabbing Burning Achy Dull Stiff & Sore

Radiating: Left/Right base of skull shoulder arm hand hip leg knee foot

ribs other: ____

What makes it better? Ice heat rest movement stretching

What makes it worse? sitting standing walking lying down sleep

overuse other: ____

Have you seen anyone else for this condition? ______________________

Were you involved in an accident? Auto, Fall, Work, etc?

List of medications you are taking: _______________________________

____

List of past Surgeries: ____

____

Do you have any other physical complaints? ________________________

____

Patient Signature : ____