Miller Chiropractic

Kent Miller, D.C.

Patient registration

Name____

Today's Date____________________ Driver license #: ____________________________

DOB______________________________________ Gender: Male Female Other

Do you Consent to being contacted through Text Messaging or Email?: YES NO

Email ____

Address ____

City____State___________Zip________________

Cell Phone________________________________ Home Phone __________________________________

Emergency contact name____

Relationship____

Phone__________________________________

Marital Status (Circle Answer): Single Married Separated Divorced Widowed

Your occupation: ____

Patient employer: ____

Have you lost any time from work? Yes NO Do you need a note for work? Yes No

Have you seen any other doctors for this condition? Yes No

Who?_____________________________ Phone:______________________

Have you seen a Chiropractor before? Yes No If yes, when? _________________________________

Referred to Office by:(Circle Answer) Clinic Heath Fair Project Fitness Internet

Relative/Friends: ____

Other:____

MEDICAL HISTORY

Please check **ALL** of the health conditions below that apply to **you** currently or in the past:

	Allergies		Epilepsy		Migraines
	Anemia		Gall bladder		Multiple sclerosis
	Arthritis		Gout		Nausea
	Asthma		Headaches		Neck pain
	Bladder troubles		Hearing Trouble		Osteoporosis
	Cancer		Heart disease		Parkinson's disease
	Cataracts		Hemorrhoids		Prostate
	Chest pain		Herniated Disc		Sciatica
	Chiari malformation		High blood pressure		Scoliosis
	Cold hands/feet		Infections		Short of breath
	Constipation		Kidney Disease		Sinus trouble
	Concussion		Liver disease		Sleeplessness
	Depression		Lower back pain		Stroke
	Diabetes		Mental disease		Thyroid problems
	Dizziness		Menstrual cramps		Ulcers

Other:____

____

Do you have a **Pacemaker** or **defibrillator**? ____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

____

____

____

____

WOMEN ONLY: (Circle Yes or NO)

Currently Pregnant? Yes No Do you take birth control pills? Yes No

Do you have children? Yes No If "Yes", type of birth? (Circle answer) Vaginal or C-Section

Epidural: Yes No Date: ________________________

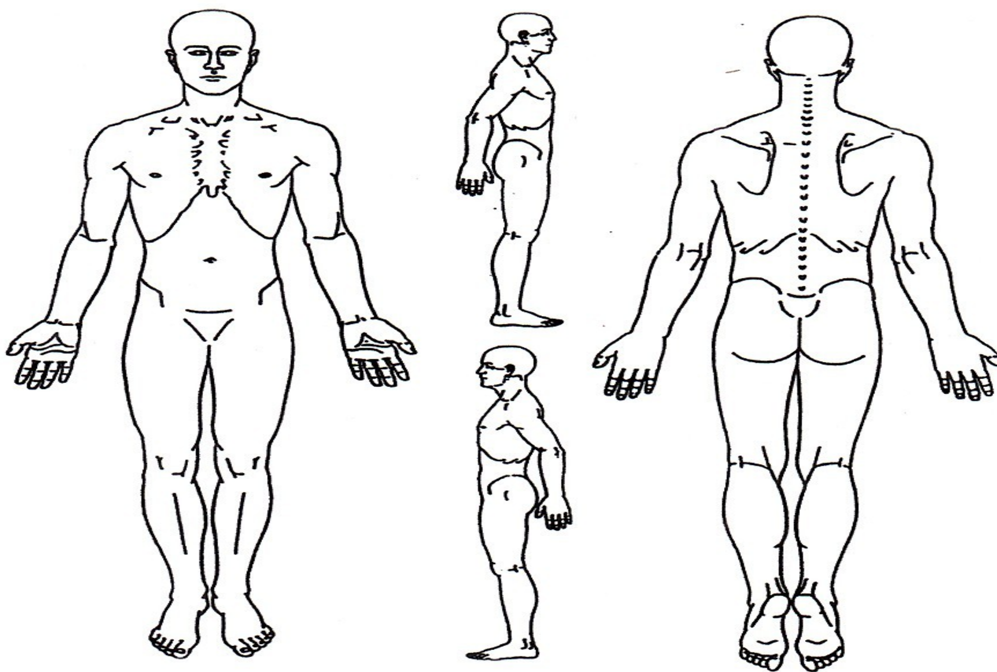
Menopause? Yes No

Indicate on the diagrams below the location/s on body and circle type of sensation/s you have been experiencing. Circle all that apply:

Aching	Burning	Cramping	Dull	Numb
Sharp	Shooting	Spasm	Stabbing	Stiffness
Stinging	Tingling	Throbbing		

Other ____

Mark where pain is:



Please describe MAIN complaints :

____

____

____

____

I **UNDERSTAND** and **AGREE** to authorize Dr. Miller and his employees to administer any examination procedures and treatments as they deem necessary.

Signature____

DATE _________________________

Miller Chiropractic

Kent Miller, D.C.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and can be provided with a copy *HIPAA Notice of Patient Privacy Policy* that provides a more complete description of information uses and disclosures.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will use or disclose health information to carry out treatment, payment, or health care options.
- We will let you know promptly if a breach
- We must follow the duties and privacy practices described in this notice and give you a copy of it upon requested.
- We will not use or share your health information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time/ Let us know in writing if you change your mind.

______________________________ ______________

Patients Signature Date

______________________________ ______________

Parent or guardian Signature *Date*

Parental/Guardian Consent for Minor Patient

Minor Patient Name: ______________________________

Name of Parent/ Guardian:______________________________

______________________________ ______________

Parent or guardian Signature **Date**

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor(s) at Miller Chiropractic and whom ever they designate as assistants to administer care to child.

Name of Child/ Minor: ______________________________

Name of Parent/ Guardian: ______________________________

______________________________ ______________

Parent or guardian Signature **Date**

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Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them. Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE THE Doctors (Dr. Kent Miller) at Miller Chiropractic TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_______________________________________ _______________

Patients Signature Date

_______________________________________ _______________

Parent or guardian Signature Date