Patient Registration Form

Patient Data:
Title: [ ] Mr. [ ] Mrs. [ ] Ms [ ] Miss [ ] Dr. (*Check One*)
First Name: _____ **Middle Initial**: _____ **Last Name**: _____
Suffix: _____(i.e., Jr, III) **How do you prefer to be addressed**: _____
Address Line 1: _____
Address Line 2: _____
City: _____ **State**: _____ **Zip Code**: _____
Home Phone: (_____) _____-_____ **Work Phone**: (_____) _____-_____
Cell Phone: (_____) _____-_____ **Is it OK to call you at work**: [ ] Yes [ ] No
Email Address: _____
Date of Birth: _____/_____/_____ **Gender**: [ ] Male [ ] Female
Social Security Number: _____-_____-_____
Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced

Spouse Data:
First Name: _____ **Middle Initial**: _____ **Last Name**: _____
Suffix: _____(i.e., Jr, III) **Phone Number**: (___) _____-_____
Date of Birth: _____/_____/_____

Emergency Contact: Check here if same as Spouse [ ]
Contact Name: _____
Relationship to Patient: _____
Phone Number: (___) _____-_____

Employer Data:
Employment Status: [ ] Employed [ ] Retired [ ] Full Time Student [ ] Part Time Student
(*Check One*) [ ] Other _____
Employer Name: _____

Insurance Information:

Insurance Company: _____

Phone #: _____ Group Number: _____

ID: _____

Primary Person Insured: _____ Date of Birth: ____/____/____

Subscriber's Name: _____ Date of Birth: ____/____/____

Relationship to Primary Insured: _____ (i.e. son, father, mother)

Chiropractic Benefits: [ ] Yes [ ] No

Effective Date: _____

Allowable Visits: _____

Co-Payment: _____

Deductible: _____

Physical Therapy: _____

Allowable Visits: _____

Referral/Pre-Certification: [ ] Yes [ ] No

Referral Information: How did you hear about our clinic? Or who referred you?

[ ] Family Member	[ ] Attorney	[ ] Internet Website	[ ] Health Class
[ ] Friend	[ ] Yellow Pages	[ ] Billboard	[ ] Brochure
[ ] Physician	[ ] Newspaper Ad	[ ] TV Commercial	[ ] Direct Mail Ad
[ ] Employer	[ ] Sign on Building	[ ] Radio	[ ] Other

If you selected "Family Member", "Friend", or "Physician" please state their name:

_____

If you selected "Other" please describe here: _____

_____

Physician Information:

Primary Care Physician: _____ **Phone Number**:_____

Fax Number:_____ **City:** _____

Other Physicians: _____

ASSIGNMENT AND RELEASE:

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Bloomsburg Spine & Sport all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Name: _____ **Date:** _____

Responsible Party Signature: _____

ACKNOWLEDGEMENT FORM
NOTICE OF PRIVACY PRACTICES

THE NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**.**

SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). The Notice describes how your medical information may be used or disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information (paper and an electronic format – all forms of information);
2. The right to request corrections to your information;
3. The right to request that your information be restricted including the right to restrict the disclosure of Protected Health Information to a health plan where a patient has paid out of pocket in full for a health care item or service.
4. The right that requires the patient to specifically authorize the use of their information in a practice's third-party marketing communication in instances where the practice receives remuneration.
5. The right to request confidential communication;
6. The right to control whether they receive fundraising communications from their health care providers.
7. The right to a report of disclosures of your information; and
8. The right to a paper copy of the Notice.

We want to assure you that your Medical/Protected Health Information is secure with us. The Notice contains information about how we will insure that your information remains private.

If you have any questions about the **NOTICE OF PRIVACY PRACTICES** form, please contact our office manager at (570) 204-9302.

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I may request a copy of this clinic's **NOTICE OF PRIVACY PRACTICES.** I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above on this **NOTICE OF PRIVACY PRACTICES** form, I further understand that the practice will offer me updated to the **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way.

_____

Patient or Representative Name (please print)

_____

Patient or Representative Signature Date

Patient refused to sign _____ Patient was unable to sign because _____

_____

The Keele STarT Neck Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

		Disagree 0	**Agree** 1
1	My neck pain has **spread down my arms (s)** at some time in the last 2 weeks	☐	☐
2	I have had pain in the **hips** or **back** at some time in the last 2 weeks	☐	☐
3	My **sleeping is moderately disturbed** because of my neck pain.	☐	☐
4	In the last 2 weeks, I have **dressed/washed more slowly** than usual because of neck pain	☐	☐
5	It's not really safe for a person with a condition like mine to be physically active	☐	☐
6	**Worrying thoughts** have been going through my mind a lot of the time	☐	☐
7	I feel that **my neck pain is terrible** and **it's never going to get any better**	☐	☐
8	In general I have **not enjoyed** all the things I used to enjoy	☐	☐

9. Overall, how **bothersome** has your neck pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): _____ **Sub Score (Q5-9):_____**

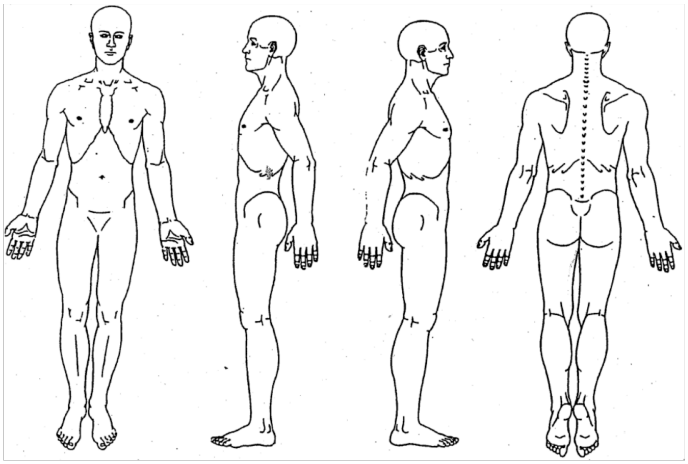
Funded by Arthritis Research UK

214 Center Street, Bloomsburg, PA 17815 / Phone: (570) 204-9302 / Fax: (570) 317-2594 / Website: www.BloomsburgSpineSport.com

Patient Name: _____ **Date:** _____

Using the following descriptive symbols, draw the location of your pain on the body outlines below

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
^^^^	=======	000000000	.....	/////////	xxxxx



Describe other pain not listed:

_____

_____

Please circle the appropriate number. Circle only one number on the scale.

Over the past week, on average, how would you rate your pain?

0	1	2	3	4	5	6	7	8	9	10

No pain — *Worst possible pain*

How confident are you in your ability to overcome your problem?

0	1	2	3	4	5	6	7	8	9	10

Total confidence — *No confidence*

How depressed do you feel as a result of your current problem?

0	1	2	3	4	5	6

Not at all — *Extremely*

Based on all the things you do to cope with, or deal with your back pain, on an average day, how much control do you feel you have over it?

0	1	2	3	4	5	6

No control — *Some* — *Complete control*

Based on all the things you do to cope with, or deal with your back pain, on an average day, how much control do you feel you have over it?

0	1	2	3	4	5	6

Can't decrease It at all — Can decrease it somewhat — Can decrease it completely

What are two important activities that you cannot do or are having trouble doing? (i.e., "I can't get dressed without help," "I can't play golf," "I can't go to work.")

Activity 1: _____
Please rate activity

0	1	2	3	4	5	6	7	8	9	10

Able to perform at same level as before problem — *Unable to perform*

Activity 2: _____
Please rate activity

0	1	2	3	4	5	6	7	8	9	10

Able to perform at same level as before problem — *Unable to perform*

Spine Health Pain Screen

Patient Name: _____ Date of Birth: _____ Date: _____

NO	YES	
_____	_____	Do you have a past history of cancer?
_____	_____	Have you had any unexplained weight loss?
_____	_____	Have you had a recent episode of fever or chills?
_____	_____	Is your pain worse at night?
_____	_____	Is your pain the same whether resting or moving?
_____	_____	Do you find that you can obtain no position of relief?
_____	_____	Are you over 50 years of age?
_____	_____	Are you younger than 20 years old with severe, disabling pain?
_____	_____	No significant improvement after 1 month of conservative care?
_____	_____	Have you had spinal pain for more than 4 consecutive weeks?

NO	YES	
_____	_____	Are you on blood thinners?
_____	_____	Do you have abdominal pain?
_____	_____	Do you have a history of high blood pressure, smoking or family obesity?
_____	_____	Do you have a history of intravenous drug use?
_____	_____	Do you have a recent urinary tract, respiratory tract, or other infection?
_____	_____	Immunosuppression medication and/or condition (HIV infection)?

NO	YES	
_____	_____	History of significant trauma from a motor vehicle accident or fall?
_____	_____	Are you over 50 and had a minor trauma/strenuous lifting injury?
_____	_____	Do you have osteoporosis (weak bones)?
_____	_____	Are you over 70 years of age?
_____	_____	Do you have a history of prolonged use of corticosteroids like prednisone or Medrol?

NO	YES	
_____	_____	Loss of bladder control?
_____	_____	Loss of bowel control?
_____	_____	Numbness in the groin region?
_____	_____	Progressive muscle weakness in the legs (do your legs give out)?

COMMENTS: _____

_____

_____

_____

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Check the appropriate box and add additional information to the right

Past Medical History Form

Medical Conditions:

Past	Present		Type	Date Diagnosed
[ ]	[ ]	Aortic Aneurysm		
[ ]	[ ]	Arthritis		
[ ]	[ ]	Auto-Immune Disease		
[ ]	[ ]	Blood Disorders		
[ ]	[ ]	Breast Lump		
[ ]	[ ]	Chemical Dependency		
[ ]	[ ]	Chicken Pox / Shingles		
[ ]	[ ]	Depression/Anxiety		
[ ]	[ ]	Diabetes		
[ ]	[ ]	Dislocation		
[ ]	[ ]	Dizziness/Fainting		
[ ]	[ ]	Epilepsy/Seizures		
[ ]	[ ]	Eye Conditions		
[ ]	[ ]	Fibromyalgia		
[ ]	[ ]	Gall Bladder Disease		
[ ]	[ ]	Headaches		
[ ]	[ ]	Heart/Vascular Disease		
[ ]	[ ]	High Cholesterol		
[ ]	[ ]	Kidney Disease		
[ ]	[ ]	Liver Disease		
[ ]	[ ]	Lung Condition		
[ ]	[ ]	Lyme Disease		
[ ]	[ ]	Metabolic Disease		
[ ]	[ ]	Multiple Sclerosis		
[ ]	[ ]	Neurological Condition		
[ ]	[ ]	Pacemaker		
[ ]	[ ]	Polio		
[ ]	[ ]	Prostate Problems		
[ ]	[ ]	Prosthesis/Prosthetics		
[ ]	[ ]	Scoliosis		
[ ]	[ ]	Skin Disorders		
[ ]	[ ]	Stroke		
[ ]	[ ]	Thyroid Problems		
[ ]	[ ]	Ulcers		
[ ]	[ ]	Visual Disturbances		
[ ]	[ ]	Other		

Surgical/Hospitalization History

Type	Date Performed	Brief Reason
[ ] Abdominal Surgery		
[ ] Back/Neck Surgery		
[ ] Heart Procedure		
[ ] Gynecological/Genitourinary		
[ ] Joint Procedure (knee, hip, etc)		
[ ] Prostate/Genitourinary		
[ ] Skin Procedures		
[ ] Oral Surgery		
[ ] Other		

Medication History

Past	Present	Name/Type	Date Prescribed	Reason
[ ]	[ ] Antibiotics			
[ ]	[ ] Anti-inflammatory Drugs			
[ ]	[ ] Birth Control Pills			
[ ]	[ ] Over the Counter Drugs			
[ ]	[ ] Pain Medication			
[ ]	[ ] Other			

Allergy History

Please list any allergies that you have.

_____

Family History

Condition	Type	Relationship	Age
[ ] Arthritis			
[ ] Back Pain/Neck Pain			
[ ] Cancer			
[ ] Cholesterol			
[ ] Depression/Anxiety			
[ ] Diabetes			
[ ] Epilepsy			
[ ] Headaches			
[ ] Heart/Vascular Disease			
[ ] High Blood Pressure			
[ ] Lung Problems			
[ ] Lupus			
[ ] Prostate Problems			
[ ] Psychiatric Illness			
[ ] Stroke			
[ ] Thyroid			

General Health History

Do you have a permanent disability rating? [ ] Yes [ ] No Rating:_____

How would you rate your overall health?

[ ] Excellent [ ] Good [ ] Average [ ] Poor [ ] Very Poor

Do you have a lack of energy? [ ] Yes [ ] No

Do you have a feeling of general discomfort? [ ] Yes [ ] No

Do you get sick often? [ ] Yes [ ] No

Occupational History

What is your current occupation?: _____

How long have you worked at your current job? _____

Is your current problem affecting your ability to perform your job? [ ] Yes [ ] No

Social History

	Type	Never	Moderately (few x/week)	Frequently (daily)
[ ] Alcohol	_____	[ ]	[ ]	[ ]
[ ] Exercise	_____	[ ]	[ ]	[ ]
[ ] Stress	_____	[ ]	[ ]	[ ]
[ ] Tobacco	_____	[ ]	[ ]	[ ]

[ ] Past [ ] Present Packs per Week:_____Number of Years:_____