



**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

Physical Therapy: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Allowable Visits: \_\_\_\_\_

Allowable Visits: \_\_\_\_\_

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

Co-Payment: \_\_\_\_\_

Deductible: \_\_\_\_\_

**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.

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Patient or Representative Name (please print)

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Patient or Representative Signature

Date

Patient refused to sign \_\_\_\_\_ Patient was unable to sign because \_\_\_\_\_

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# The Keele STarT Back Screening Tool

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

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

	Disagree 0	Agree 1
1 My back pain has <b>spread down my leg(s)</b> at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
2 I have had pain in the <b>shoulder</b> or <b>neck</b> at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
3 I have only <b>walked short distances</b> because of my back pain	<input type="checkbox"/>	<input type="checkbox"/>
4 In the last 2 weeks, I have <b>dressed more slowly</b> than usual because of back pain	<input type="checkbox"/>	<input type="checkbox"/>
5 It's not really safe for a person with a condition like mine to be physically active	<input type="checkbox"/>	<input type="checkbox"/>
6 <b>Worrying thoughts</b> have been going through my mind a lot of the time	<input type="checkbox"/>	<input type="checkbox"/>
7 I feel that <b>my back pain is terrible</b> and <b>it's never going to get any better</b>	<input type="checkbox"/>	<input type="checkbox"/>
8 In general I have <b>not enjoyed</b> all the things I used to enjoy	<input type="checkbox"/>	<input type="checkbox"/>
9. Overall, how <b>bothersome</b> has your back pain been in the <b>last 2 weeks</b> ?		

Not at all

Slightly

Moderately

Very much

Extremely






0

0

0

1

1

**Total score (all 9):** \_\_\_\_\_

**Sub Score (Q5-9):** \_\_\_\_\_

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Funded by Arthritis Research UK

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

<u>ACHE</u> ^^^	<u>BURNING</u> =====	<u>NUMBNESS</u> 00000000	<u>PINS &amp; NEEDLES</u> .....	<u>STABBING</u> /////	<u>OTHER</u> xxxxx
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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
					<i>Worst possible pain</i>					
<i>No pain</i>										

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

0	1	2	3	4	5	6	7	8	9	10
					<i>No confidence</i>					
<i>Total confidence</i>										

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

0	1	2	3	4	5	6
<i>Not at all</i>						<i>Extremely</i>

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
<i>No control</i>		<i>Some</i>		<i>Complete control</i>		

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
<i>Can't decrease it at all</i>		<i>Can decrease it somewhat</i>		<i>Can decrease it completely</i>		

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
<i>Able to perform at same level as before problem</i>					<i>Unable to perform</i>					

Activity 2: \_\_\_\_\_  
Please rate activity

0	1	2	3	4	5	6	7	8	9	10
<i>Able to perform at same level as before problem</i>					<i>Unable to perform</i>					



## Spine Health Pain Screen

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

<b>NO</b>	<b>YES</b>	
_____	_____	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?

<b>NO</b>	<b>YES</b>	
_____	_____	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)?

<b>NO</b>	<b>YES</b>	
_____	_____	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?

<b>NO</b>	<b>YES</b>	
_____	_____	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:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\*\*Check the appropriate box and add additional information to the right\*\*

## Past Medical History Form

### Medical Conditions:

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

### Surgical/Hospitalization History

<u>Type</u>	<u>Date Performed</u>	<u>Brief Reason</u>
<input type="checkbox"/> Abdominal Surgery	_____	_____
<input type="checkbox"/> Back/Neck Surgery	_____	_____
<input type="checkbox"/> Heart Procedure	_____	_____
<input type="checkbox"/> Gynecological/Genitourinary	_____	_____
<input type="checkbox"/> Joint Procedure (knee, hip, etc)	_____	_____
<input type="checkbox"/> Prostate/Genitourinary	_____	_____
<input type="checkbox"/> Skin Procedures	_____	_____
<input type="checkbox"/> Oral Surgery	_____	_____
<input type="checkbox"/> Other	_____	_____

**Medication History**

<u>Past</u>	<u>Present</u>	<u>Name/Type</u>	<u>Date Prescribed</u>	<u>Reason</u>
<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Anti-inflammatory Drugs	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Over the Counter Drugs	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pain Medication	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other	_____	_____

**Allergy History**

Please list any allergies that you have.

**Family History**

<u>Condition</u>	<u>Type</u>	<u>Relationship</u>	<u>Age</u>
<input type="checkbox"/> Arthritis	_____	_____	_____
<input type="checkbox"/> Back Pain/Neck Pain	_____	_____	_____
<input type="checkbox"/> Cancer	_____	_____	_____
<input type="checkbox"/> Cholesterol	_____	_____	_____
<input type="checkbox"/> Depression/Anxiety	_____	_____	_____
<input type="checkbox"/> Diabetes	_____	_____	_____
<input type="checkbox"/> Epilepsy	_____	_____	_____
<input type="checkbox"/> Headaches	_____	_____	_____
<input type="checkbox"/> Heart/Vascular Disease	_____	_____	_____
<input type="checkbox"/> High Blood Pressure	_____	_____	_____
<input type="checkbox"/> Lung Problems	_____	_____	_____
<input type="checkbox"/> Lupus	_____	_____	_____
<input type="checkbox"/> Prostate Problems	_____	_____	_____
<input type="checkbox"/> Psychiatric Illness	_____	_____	_____
<input type="checkbox"/> Stroke	_____	_____	_____
<input type="checkbox"/> 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**

	<u>Type</u>	<u>Never</u>	<u>Moderately</u> (few x/week)	<u>Frequently</u> (daily)
<input type="checkbox"/> Alcohol	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Exercise	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stress	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tobacco	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Past  Present Packs per Week: \_\_\_\_\_ Number of Years: \_\_\_\_\_