Meridian Medicine Registration Form

Today's date:

PATIENT INFORMATION

Patient's last name:	First Name:	Preferred Name:	MI:	Gender at Birth: ☐M ☐F Current/Preferred Gender:

Is patient a minor? ☐Yes ☐No	If Yes, who is legal guardian/parent responsible for him/her?	Date of Birth	Age:	Preferred Pronoun

Emergency Contact Name:	Relationship:	Phone:

CONTACT INFORMATION

Address:			Home Phone: ☐ Leave messages/test results here ( )
City:	State:	Zip Code:	Mobile Phone: ☐ Leave messages/test results here ( )
Occupation:	Employer/School:		Work Phone: ( )
Email:		May we add you to our QUARTERLY newsletter? ☐ Yes ☐ No	

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr.

☐Family	☐Event (Name):	☐Sign/location	☐Yellow Pages	☐Internet (Which Site?):

☐Family/Friend/Co-Worker/Other (Name):

INSURANCE INFORMATION

(Skip if we copy your card)

Insurance Carrier Name (i.e., Allstate, Geico, etc.)
Policy Number:
Insurance Policy Holder Name:
Address:
Phone:

ACCIDENT INFORMATION

Type of Accident ☐ Automobile ☐ Work-Related ☐ Home ☐ Other (please indicate):

Have you reported this incident? ☐ Yes ☐ No	If **Yes**, to whom have you reported:

If **automobile accident related**, please complete **Personal Injury Questionnaire**

If **work related**, please complete the following:

Employer:	Date of injury:	Claim # (if claim is open):

INJURIES / SURGERIES

PLEASE COMPLETE THE FOLLOWING WITH AN APPROXIMATE DATE AND A BRIEF DESCRIPTION.

Falls / Head Injuries: _____

Broken Bones / Dislocations: _____

Surgeries: _____

Work Injuries: _____

Auto Accidents: _____

_____

_____

(Please See Reverse Side)

Meridian Medicine Registration Form

HEALTH HISTORY

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other: _____

Name of doctor(s) who have treated you for your current condition:

For best results, we like to communicate with your Health Care Providers. May we send them periodic reports of your progress?

☐ Yes ☐ No

Date of Last:

Physical Exam:_____

Spinal Adjustment:_____

Spinal X-Ray/MRI:_____

PLEASE CHECK ALL THAT APPLY

☐	Alcoholism	☐	Glaucoma	☐	Numbness	☐	Tremors
☐	AIDS/HIV	☐	Goiter	☐	Osteoarthritis	☐	Tuberculosis
☐	Allergy Shots	☐	Gout	☐	Osteoporosis	☐	Tumors, Growths
☐	Anemia	☐	Headaches	☐	Pacemaker	☐	Typhoid Fever
☐	Anorexia / Bulimia	☐	Hearing Loss	☐	Parkinson's Disease	☐	Ulcers
☐	Appendicitis	☐	Heart Attack	☐	Pinched Nerve	☐	Whooping Cough
☐	Arthritis	☐	Hemorrhoids	☐	Pneumonia	☐	Vision Problems
☐	Asthma	☐	Hepatitis	☐	Polio	☐	Fever (prolonged)
☐	Bed Wetting	☐	Hernia	☐	Prostate Problem	☐	Mumps
☐	Bleeding Disorders	☐	Herniated Disc	☐	Prosthesis	☐	TMJ (Jaw)
☐	Bronchitis	☐	High Blood Pressure	☐	Psychiatric Care	**Women Only:**	
☐	Cancer	☐	High Cholesterol	☐	Rheumatic Fever	☐	Hysterectomy
☐	Chemical Dependency	☐	Infertility	☐	Rheumatoid Arthritis	☐	Miscarriage
☐	Chicken Pox	☐	Kidney Disease	☐	Ringing in Ears	☐	Menopause
☐	Diabetes	☐	Liver Disease	☐	Scarlet Fever	☐	PMS
☐	Difficulty Breathing	☐	Low Back Pain	☐	Sinus Infections	☐	Irregular Menses
☐	Dizziness	☐	Measles	☐	STDs	☐	Cramps
☐	Emphysema	☐	Migraines	☐	Stroke	☐	Breast Problems
☐	Epilepsy	☐	Mononucleosis	☐	Thyroid Problems	☐	Pregnant
☐	Fatigue	☐	Multiple Sclerosis	☐			Due Date: _____
☐	Frequent Colds						

MEDICATIONS

Medications:

Allergies (if any):

Vitamins/Herbs/Mineral/Supplements:

PERSONAL LIFESTYLE

Exercise	Work Activity	Stress Level	Habits	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs/day:
☐ 1-2 x week	☐ Standing	☐ Medium	☐ Alcohol	Drinks/week:
☐ 3-4 x week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups/day:
☐ 5+ x week	☐ Heavy Labor	☐ Causes:		

Type of Exercise: _____

Eating Habits

In the last 24 hours, how many servings of fruits and vegetables have you consumed: _____

Is this typical? ☐ Yes ☐ No

Average fast food you eat per week: ☐ 0 (None) ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 4+

ASSIGNMENT

I, the undersigned, certify that I (or my dependent) have insurance with _____ and I authorize direct payment to Meridian Medicine for any insurance benefits otherwise payable to me for the services rendered. I understand that I am responsible for all charges if not paid by insurance. I authorize the doctor to release all information necessary to secure benefits. I authorize the use of this signature on all insurance claims. I understand that a copy of my insurance card is to be kept on file for the purposes of billing for all services rendered herein. The above information is true and correct to the best of my knowledge. I accept and acknowledge ultimate responsibility for all charges incurred in this office. All fees are payable at the time of service, unless other arrangements are made in advance.

_____ _____

Patient/Guardian signature *Date*

MERIDIAN | MEDICINE

Patient History

Date:

PATIENT INFORMATION

LAST NAME: FIRST NAME:	AGE:	RIGHT HANDED ☐	LEFT HANDED ☐

HISTORY

What brings you in today? Check all that apply: ☐ Back Pain ☐ Neck Pain ☐ Mid Back Pain ☐ Headaches ☐ Extremity Pain (Foot, Hip, Arm, Leg, Ankle, Wrist, Arm, Shoulder) ☐ Other:

Of the health concerns you listed above, which is the most important to you?

How long has it been occurring?	In the last week, how often has it occurred?

Besides what you checked above, do you have any other health concerns, even if you don't think chiropractic can help?

ACCIDENTS/INJURIES/TRAUMAS

Have you ever had any car accidents, slips/falls, sports injuries? (Even if they seem minor or unrelated to current concern)

PRIOR TREATMENTS

Prior treatments tried for this concern: ☐ Ice ☐ Heat ☐ Stretching ☐ Foam Roller ☐ Massage ☐ Icy Hot/Pain Patch ☐ PT Medications-- Please list: Other:

GOALS

What are some of the things this is limiting or preventing you from doing:

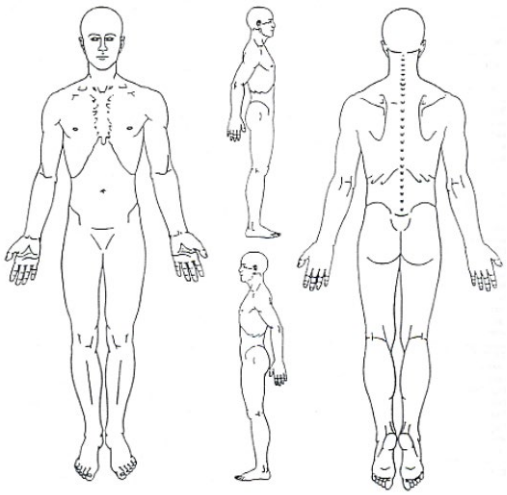
What are your health goals for the next six months:

How long have you been considering chiropractic care:

PAIN DIAGRAM

Please draw the location and type of pain on the body diagrams:

Ache	**Burning**	**Numbness**
MMMMM	-----	O O O O O
Pins/Needles	**Stabbing**	**Other**
ooooo	/////	xxxxx



(Please See Reverse Side)

Functional Rating Index

For use with Neck and/or Back Problems

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item, please **circle** the number which most closely describes your condition right now.

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Signature: _____ Date: _____

Meridian Medical
Notice of Privacy Practices

ACKNOWLEDGEMENT

Our ***Notice of Privacy Practices*** describes in more detail how your health information may be used and disclosed, and how you can access your information. An additional copy of our ***Notice of Privacy Practices*** can be obtained at our office.

By my signature below I acknowledge having been given the opportunity to review Meridian Medical's ***Notice of Privacy Practices***.

_____ _____

Patient/Legally Authorized Signature Date

_____

Printed Name

Meridian Medical
Informed Consent for Chiropractic Adjustments

Chiropractic treatment consists of manipulations of joints and soft tissues, using the hand and/or a mechanical instrument. You may feel joint movement, and you may hear joint clicks or other noises. Some patients will feel some stiffness and soreness following the first few days of treatment, these are normal and not a cause for concern. There are different techniques used in chiropractic spinal adjustments. There are also alternatives to chiropractic care, including but not limited to: Physical therapy, massage therapy, osteopathic manipulations, and medical care. There are also material risks inherent in the above listed alternatives, which should be discussed between you and the specialty care provider. You also have the option of not seeking any care. The risk of remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are certain risks which may arise during the exam and treatment. Those complications include: strokes or stroke-like conditions, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, pathological fracture, cervical disc protrusions, cervical dislocations, costovertebral strains, rib fractures, costochondral separations, compression of the cauda equina. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. The risks of massage are bruising, local tenderness, and the release of toxins in the body. I have read or have had read to me the above explanation of the nature and purpose of chiropractic adjustments, other alternatives/procedures for care, massage, and possible risks. I have also had the opportunity to ask questions about its content and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have, myself, decided that it is in my best interest to undergo the treatment recommended, and listed below. Having been informed of the risks, I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures, and diagnostic x-rays-if warranted, massage, and the use of natural substances such as vitamins, minerals, or other natural substances on me or on the patient named below, for whom I am legally responsible, by the doctor of chiropractic named below and/or licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or servicing as backup for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient/Legally Authorized Signature Date

_____

Printed Name