Moon Valley Chiropractic, Jamey Reichow, DC
15420 N &7th Street, Suite B, Phoenix, AZ 85022
Phone: 602-298-0292n Fax 602-298-6961

PATIENT REGISTRATION AND HISTORY QUESTIONNAIRE

Name _____ Referred by _____ Date _____

Age ___ Birth Date _____ Email address _____

Address _____ City _____ State _____ Zip _____

Social Security #_____Cell # _____ Home # _____

Occupation _____ Employer _____ Work #_____

Spouse's Name _____ Spouse's Employer _____

In Case Of Emergency, Notify _____ Relationship _____ Phone _____

Chief complaint and/or reason for this visit: _____

Date and Time of onset of symptoms: _____

What makes your symptoms better? _____ What makes them worse? _____

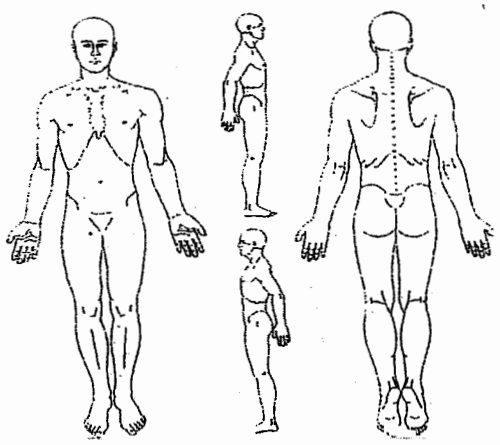
What type of symptoms do you have? (ache, burn, dull, sharp, throbbing) _____

Are symptoms: ❒ Constant ≥ 76% ❒ Frequent 51-75% ❒ Occasional 26-50% ❒ Intermittent ≤ 25% of waking hours

Please mark on the diagram the following symbols as they relate to your symptoms:

SS = spasms **ST** = stiffness
DP = dull pain **SP** = sharp pain

SH = shooting pain **TI** = tingling
NU = numbness **O** = other



Please list all medications you are taking:	Dosage	Frequency	Reason

List any allergies to medications, food, environment, etc.: _____
Are you pregnant? ❒ Yes ❒ No
Do you smoke? ❒ Yes ❒ No How much? _____ Do you drink? ❒ Yes ❒ No How much? _____

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Patient Name: _____ Date: _____

Please list all serious illness and serious accidents	Month and Year	City and State

Please list any recent X-rays, lab or other tests	Date	Doctor/Facility

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING (please circle all that are applicable):

Tuberculosis	Lung Disease	Gout	Diabetes
Kidney Disease	Stomach / Ulcer	Heart Disease	Hepatitis
Sciatica	Blood Pressure	Transfusion	Polio / MS
Colon Disease	Stroke	Cancer	Bleeding
Paralysis	Seizures	Arthritis	Asthma
Anemia	Thyroid Disease	Drug Dependence	AIDS

Any other condition that the doctor should be aware of: _____

_____

HIPPA Compliance

Moon Valley Chiropractic is required by law to maintain the HIPPA Notice of Privacy Practices. This notice explains our leagal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: _____ **Date** _____

Parent or Guardian Signature: _____ **Date** _____

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Patient _____ Date _____

0 = Never Had **1 = Has Currently** **2 = Previously Had**

GENERAL	MUSCULOSKELETAL	NEUROLOGICAL
Recent Weight Gain	Arthritis	Lightheaded / Dizzy
Recent Weight Loss	Rheumatoid Arthritis	Memory Loss
Fatigue	Broken Bones	Headaches
Fever	Osteoporosis	Migraines
Allergies	Gout	Numbness
Loss of Appetite	Scoliosis	Weakness
Chills	Spinal Trauma	Stroke
Cancer of Any Kind	Joint Pain (anywhere)	Tingling / Numbness

CARDIOVASCULAR	RESPIRATYORY	INTEGUMENTARY (SKIN)
Heart Attack	Coughing	Bruise Easily
Swelling of Ankles	Coughing Up Blood	Skin Rashes
High Blood Pressure	Chronic Cough	Discolorations
Low Blood Pressure	Chest Pain	Psoriasis
Shortness of Breath	Asthma	Changes in Moles
Pain Down Left Arm	Pneumonia	Sores
Profuse Sweating	Bronchitis	Scars
High Cholesterol	Tuberculosis	Itching

EYES, EARS, NOSE & THROAT	GASTROINTESTINAL	GENITOURINARY
Blurred Vision	Gall Bladder Problems	Painful Urination
Double Vision	Liver Problems	Blood in Urine
Ear Pain	Pain over Stomach	Frequent Urination
Nose Bleeds	Colitis	Kidney Infection
Hoarsness	Ulcers	Kidney Stones
Glaucoma	Hiatal Hernia	Incontinence
Dental Problems	Blood in Stool	

Other / Explanations

_____

_____

_____

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INFORMED CONSENT

THE NATURE OF THE CHIROPRACTIC MANIPULATION: I will use my hands, an instrument, or both to move the joints in your body; this may result in a audible "pop" or "click".

THE MATERIAL RISKS INHERENT IN AN ADJUSTMENT: As with any healthcare procedure, there are certain complications that may arise during a chiropractic manipulation. This may include strains, dislocations, fractures, disc injuries and stroke; this list is not all inclusive.

THE PROBABILITY OF THESE RISKS: Fractures are rare and can result from an underlying weakness in the bones. The other complications listed are also considered rare. One source states that stroke is a possible occurrence in greater than 1 of 1 million cases; even so, we employ tests during our examination to identify if you may be susceptible to these types of injuries.

ANCILLARY TREATMENTS RECOMMENDED: Ice, moist heat packs, ultrasound, electrical muscle stimulations, stretching/strengthening exercises, massage therapy, laser, neuromuscular re-education, and mechanical traction.

RISKS: Ice, ultrasound with heat, and electrical muscle stimulation (EMS) can cause burning. The EMS can cause skin irritation underneath the active pads. Stretching/strengthening exercises and mechanical traction can cause temporary post-treatment soreness or reflex muscle spasms. This list is not all inclusive.

BE SURE YOU HAVE READ AND UNDERSTAND THE ABOVE

CANCELATION POLICY: Your business is valuable and your cooperation is appreciated. We are making a commitment to you to guarantee your appointment time and refusing all other requests once you have made the appointment.

- A 24 hour cancelation notice is required for ANY scheduled appointments.
- Missed or no-show appoints may incur a $25.00 fee
- Late arrivals may not receive the full session time allotted for the treatments booked, FULL payment is still required.

I HAVE READ AND I AGREE WITH THE ABOVE

Signature _____ Date _____

Print _____