

Patient Registration and History Questionnaire

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Date: \_\_\_\_\_  
LAST FIRST MIDDLE

Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_  Male  Female

City, State, Zip: \_\_\_\_\_ Marital Status:  M  S  W  D # of Children \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

**In case of emergency, notify** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone (\_\_\_\_\_)** \_\_\_\_\_

**Chief Complaint or Reason for Office Visit:** \_\_\_\_\_

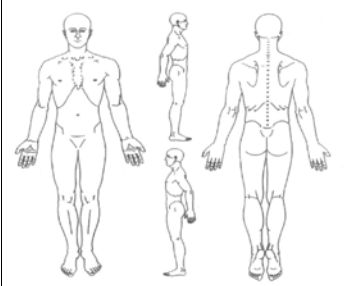
Specific Date and Time of Onset of Symptoms: \_\_\_\_\_

What makes your symptoms **better**? \_\_\_\_\_ What makes your symptoms **worse**? \_\_\_\_\_

What is the quality of your symptoms? (**ache, burn, dull, sharp, throbbing**): \_\_\_\_\_

Are your symptoms local or do they travel to another area? (If they travel, to where?) \_\_\_\_\_

Are symptoms; Constant >76% Frequent 51-75% Occasional 26-50% Intermittent <25% **of your waking hours**

<p align="center"><b>Please mark on the diagram to the right the following symbols as they relate to your symptoms:</b></p> <p>SS = spasms                      ST = stiffness          DP = dull pain                    SP = sharp pain          SH = shooting pain            TI = tingling          NU = numbness                 O = Other</p>	
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Please list all medications and dosage: Frequency For What Illness?

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List any allergies to medications, foods or other: \_\_\_\_\_

**Are you pregnant?**  Yes  No First day of last menstrual cycle: \_\_\_\_\_

Do you smoke?  Yes  No; How much? \_\_\_\_\_ Do you drink alcohol?  Yes  No; How much? \_\_\_\_\_

**Dr. Brian Self**, Chiropractic Physician **Arizona Pain and Wellness Centers, L.L.C.**  
**4915 E. Baseline Rd., Ste.101 Gilbert, AZ 85234 (602) 281-3244 Fax (602) 391-2810**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please list all serious illness and serious accidents:**                      **Month and Year**                      **City, State**

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**Please list any recent x-rays, lab or other tests:**                      **Date**                      **Facility/Doctor**

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**DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:**

- |   |  |  |   |
|---|--|--|---|
| Tuberculosis <input type="checkbox"/> Yes   | Lung Disease <input type="checkbox"/> Yes    | Gout <input type="checkbox"/> Yes            | Diabetes <input type="checkbox"/> Yes   |
| Kidney Disease <input type="checkbox"/> Yes | Stomach/Ulcer <input type="checkbox"/> Yes   | Heart Disease <input type="checkbox"/> Yes   | Hepatitis <input type="checkbox"/> Yes  |
| Sciatica <input type="checkbox"/> Yes       | Blood Pressure <input type="checkbox"/> Yes  | Transfusion <input type="checkbox"/> Yes     | Polio / MS <input type="checkbox"/> Yes |
| Colon Disease <input type="checkbox"/> Yes  | Stroke <input type="checkbox"/> Yes          | Cancer <input type="checkbox"/> Yes          | Bleeding <input type="checkbox"/> Yes   |
| Paralysis <input type="checkbox"/> Yes      | Seizures <input type="checkbox"/> Yes        | Arthritis <input type="checkbox"/> Yes       | Asthma <input type="checkbox"/> Yes     |
| Anemia <input type="checkbox"/> Yes         | Thyroid Disease <input type="checkbox"/> Yes | Drug Dependence <input type="checkbox"/> Yes | AIDS <input type="checkbox"/> Yes       |

Any other condition(s) not listed above that the doctor should be made aware of:

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**YOUR GROUP HEALTH INSURANCE COMPANY:** \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_ Insured: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Policy #: \_\_\_\_\_ SS#: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

**HIPAA Compliance**

Brian Self, DC is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal 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: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Initials: \_\_\_\_\_

**Arizona Pain and Wellness Centers  
4915 E. Baseline Rd. Suite 101  
(602) 281-3244 Fax:(602) 391-2810**

<b>Patient RF Questionnaire</b>
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**Patient** \_\_\_\_\_ **Date** \_\_\_\_\_ **Age** \_\_\_\_\_

Please check the appropriate response. If "yes", please explain. If you are not sure, check the "?" box. **THANK YOU!**

**NO YES ?**

- Do you have a past history of cancer?
- Have you had any unexplained weight loss?
- Does your pain improve with rest?
- Are you over 50 years old?
- Failure to respond to a course of conservative care (4-6 weeks)?
- Have you had spinal pain greater than 4 weeks?

**NO YES ?**

- Prolonged use of corticosteroids (such as organ transplant Rx)?
- Intravenous drug use?
- Current or recent urinary tract, respiratory tract or other infection?
- Immunosuppression medication &/or condition?

**NO YES ?**

- History of significant trauma?
- Minor trauma in person >50 years old?
- Do you have osteoporosis (weak bones)?
- Are you over 70 years old?
- Any history of prolonged use of corticosteroids?

**NO YES ?**

- Acute onset urinary retention or overflow incontinence (wet underwear)
- Loss of anal sphincter tone or fecal incontinence (bowel accidents)
- Saddle anesthesia (numbness in the groin region)
- Global or progressive muscle weakness in the legs (legs give out)

**COMMENTS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Arizona Pain and Wellness Centers**

# **Patient Disclaimer**

I understand the following:

- ❖ FDA classifies the equipment as “powered traction equipment”
- ❖ Carriers may deny the care as “experimental”
- ❖ The American Medical Association (AMA) has said that vertebral axial decompression (VAD) represents a form of mechanical traction

I also understand that Suarez Chiropractic Clinic or any legal representative thereof cannot be held responsible or liable for any injury or change in my symptoms do to none compliance with treatment recommendations or any circumstance outside of our control.

If you qualify as a patient, would you be willing to allow another patient who might be suffering from a similar condition to contact you and ask you about your treatment? \_\_\_\_\_ (not mandatory)

I do not have any of the following conditions:

- Pregnancy
- Metastatic Cancer
- Severe Osteoporosis
- Prior Lumbar fusion
- Spondylolisththesis Grade 3 or 4
- L1-L5 compression fx <12 months Pars Defect
- Pathologic Aortic Aneurysm (>3.5)
- Pelvic or abdominal Cancer
- Disc space infection
- Severe Peripheral Neuropathy
- Cognitive dysfunction.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

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### Informed Consent

**The nature of the chiropractic manipulation:** I will use either my hands an instrument or both to move the joints of your body; this may result in an 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 those risks:** Fractures are rare and can result from an underlying weakness in the bones. The other complications listed are considered rare. One source states that stroke is a possible occurrence in 1/1,000,000 cases or higher, even so we employ tests during our examination to identify if you may be susceptible to that kind of injury.

**Ancillary treatments recommended:** Ice, Moist Heat Packs, Ultrasound, Electrical Muscle Stimulations, Stretching/Strengthening Exercises, Massage Therapy, Diathermy, Laser, Neuromuscular Re-education, Graston Technique and Decompression Spinal Traction

**Risks involved with the recommended ancillary treatments:**

Ice, Heat and Electrical Muscle Stimulations (EMS) can cause burning. The EMS can cause skin irritation underneath the active pads. Stretching/Strengthening Exercises and Decompression Spinal Traction can cause temporary post-treatment soreness or reflex muscle spasms. Graston technique can cause mild bruising and skin redness. This list is not all inclusive.

**Other treatment options for your condition can include:** Medical care with prescription drugs, self management with over-the-counter medication, rest, and/or surgery. There are material risks inherent in each of these options including but not limited to: addiction to medication, side effects of medication, improper self dosages and surgical risks including complications from either the procedure and the anesthesia.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE**

I have read or have had read to me the above explanation of the chiropractic adjustment and the related treatment. I have discussed it with the doctor 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 I have decided that it was in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

**Patient Printed Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Dr.** \_\_\_\_\_

**The patient had the following questions and was supplied the following answers:**

\_\_\_\_\_  
\_\_\_\_\_

**It is my clinical opinion this patient is oriented to time and place:**      **Yes**      **No**

**It is my clinical opinion this patient was able to understand the language involved:** **Yes**   **No**