REGISTRATION
Treasure Valley Chiropractic Spine Management

Date: _____ Phone: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____Biological Gender: □ M □ F

Age: ____ Birthdate: _____ □ Single □ Married □ Widowed □ Separated □ Divorced

Social Security #: _____ Email: _____

*Person to contact in an emergency (Name and Phone #): _____

Who may we thank for referring you, or how did you find us? _____

Present Complaints (Please circle the appropriate ones)

Group 1	Group 2	Group 3
A. Headache	Loss of memory	Blurred vision
B. Neck pain	Depression	Fainting
C. Upper Back pain	Ears ringing/buzzing	Eye strain or pain
D. Midback pain	Nervousness	Irritability
E. Rib pain	Dizzy or Unbalanced	Double vision
F. Lower back pain	Shortness of breath	Loss of smell
G. Hip/knee/ankle: right/left	Fear	Chest pain
H. Shoulder/elbow/wrist: right/left	Confusion	Mental dullness/fog
I. Chest pain	Pins and needles in arms/hands right/left	Pins and needles in legs/feet right/left

No Complaints/Wellness Care? □
Are any complaints from Group 2 &/or Group 3 SUDDEN/NEW? Yes/No

Medical Implants: _____ **Medical alerts:** _____
Surgical Implants: _____ **Pregnancy:** **yes** ___ **no** ___

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Excruciating Pain**

*__For multiple complaints__, place the corresponding Letter above into the Numbered Box.
For example, if neck pain is 7 and low back pain is 3:

0	1	2	3 F	4	5	6	7 B	8	9	10

Any major traumas in the last 20+ years? _____

Prior chiropractic care? Yes/No If so, when was the most recent treatment? _____

Medications: *(please list all medications and supplements that you currently take)*

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies: *(please list all medications that cause allergic reaction)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____ Date _____
_____ _____
_____ _____
_____ _____

Personal Medical History & Review of Systems:
Please indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

□ asthma □ pulmonary embolism □ respiratory arrest
□ COPD □ pneumonia □ sleep apnea
□ emphysema □ tuberculosis □ other: _____

Cardiac / Heart and peripheral vascular disease

□ chest pain / angina □ high blood pressure □ irregular heartbeat, arrhythmia
□ heart attack □ heart murmur, valve disorder □ peripheral vascular disease
□ congestive heart failure □ mitral valve prolapse □ deep vein thrombosis
□ other: _____ □ bleeding problems

Neurologic Disorders

□ stroke or TIA □ Parkinson's □ cerebral palsy
□ peripheral neuropathy □ MS □ polio
□ other: _____

Bone & Joint Disorders

□ osteoarthritis □ gout □ osteomyelitis
□ rheumatoid arthritis □ lupus □ ankylosing spondylitis
□ other: _____

Patient Name: _____ Date: _____

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer □ diverticulitis □ hepatitis - Type _____
□ acid reflux, GERD □ irritable bowel □ liver disease
□ GI bleed □ inflammatory bowel disease
□ other: _____

Genitourinary Disorders

□ urinary tract infection □ kidney problems □ dialysis, kidney failure
□ bladder problems □ kidney stones □ other: _____

Metabolic & Other Disorders

□ Diabetes x _____ years □ skin disorder _____ □ depression
□ thyroid problems □ psoriasis □ anxiety
□ sickle cell disease □ any skin ulcer □ alcohol or drug dependency
□ high cholesterol or lipids □ tooth abscess, gingivitis □ other: _____

Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____
_____

Family History:

Please indicate with an "X" any significant family medical history or problems.

□ asthma □ tuberculosis □ sleep apnea
□ COPD or Emphysema □ other lung :_____
□ heart attack, myocardial infarction □ congestive heart failure
□ irregular heartbeat, arrhythmia □ bleeding problems □ Peripheral neuropathy
□ MS or Parkinson's □ other neuro :_____
□ osteoarthritis □ Lupus □ gout
□ rheumatoid arthritis □ Other bone & joint: _____
□ acid reflux, GERD □ inflammatory bowel disease □ hepatitis - Type _____
□ liver disease □ other GI :_____
□ kidney problems □ dialysis, kidney failure
□ diabetes □ psoriasis □ high cholesterol or lipids
□ thyroid problems □ sickle cell disease □ any skin ulcer
□ Malignant hyperthermia

Cancer : any type -- please specify
_____

Other medical problems NOT included above (explain)
_____
_____

Primary Care Physician:

Name & Address: _____
Phone #:_____

Patient Name: _____ Date: _____

Financial Policy for Treasure Valley Chiropractic Spine Management

Our goal is to provide our patients with the best possible care and to maintain a healthy physician-patient relationship. We believe these objectives are best achieved when our patients are clearly informed of our financial policy.

Insurance Coverage: By receiving services from our office, you have created a legal obligation between you and this office and agree to pay for our services. Your insurance policy is an agreement between you and your insurer, not between your insurance company and our office, even if this office is a participating provider in your network. You are responsible to pay for any care rendered that is determined to be non-covered, even after initial verification for coverage. Our office can contact your insurer to inquire about your benefits. Most insurers provide and initial "verification" of coverage but do not guarantee that payment will be made.

Non-insurance/Pay at the Time-of-Service: If you do not have insurance or do not make us aware or coverage, you can pay at the time that services are rendered. Payment must be collected in full at the time of service to receive any discounted rates reflected by decreased administrative costs through not billing insurance.

PATIENT INSURANCE INFORMATION: Do you have insurance you'd like us to bill? Yes/No

(if not, skip this section)

Insured's Name: _____
Last Name First Name Initial

Patient Agreement:

ASSIGNMENT AND RELEASE: I, the undersigned, have insurance coverage with_____
Name of Insurance Company

and assign directly to **Dr. David Herrin/Treasure Valley Chiropractic Spine Management** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Please check any and all insurance coverage you or your spouse has applicable in this case.

☐ Medicare	☐ Pacific Source	☐ Auto Collision
☐ Blue Cross	☐ Major Medical	☐ Union Plan
☐ Blue Shield	☐ Worker's Compensation	☐ Other _____

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____

Major Medical or Auto Insurance (if applicable): A separate, additional form will be used in this case

Date of Collision: _____Insurance Company Name: _____
Adjuster: _____
Address & Phone #: _____
Claim #: _____ Policy #: _____ Effective Date: _____

LEGAL INFORMATION (if applicable): Attorney Name:_____
Attorney Address & Phone #: _____

I understand and agree to abide by the financial policy of this office.

Patient Name: _____ Patient Signature: _____ Date: _____