

CHIROPRACTIC REGISTRATION AND HISTORY

1

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

2

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ 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 by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

3

PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4

ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

5

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

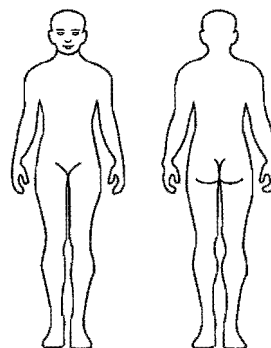
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



6

HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | | | |
|---------------------|--|---------------------|--|----------------------|--|------------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually Transmitted Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

- Smoking Packs/Day _____
 Alcohol Drinks/Week _____
 Coffee/Caffeine Drinks Cups/Day _____
 High Stress Level Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

7

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

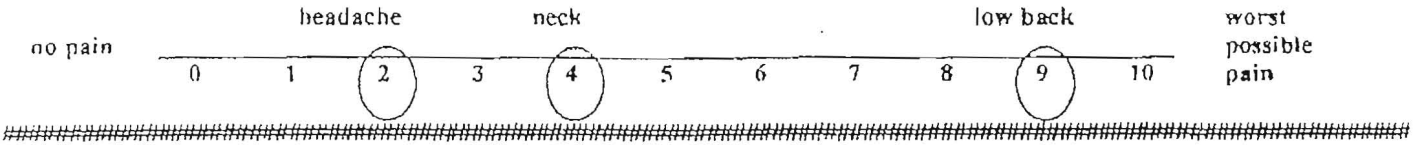
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

QUADRUPLE VISUAL ANALOGUE SCALE

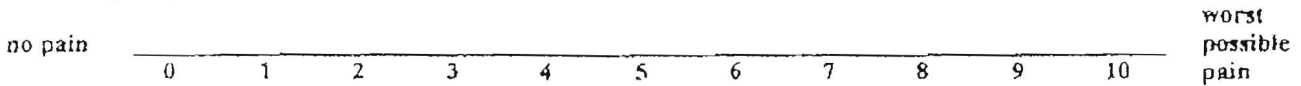
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

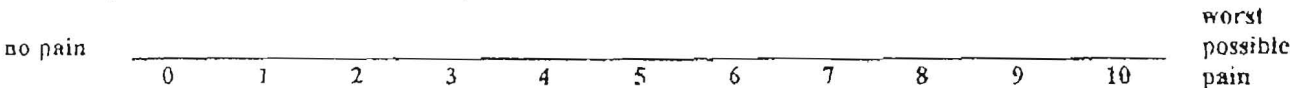
EXAMPLE:



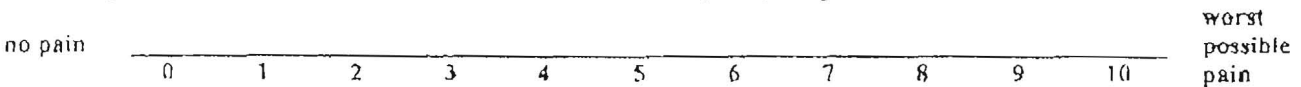
1. What is your pain **RIGHT NOW**?



2. What is your **TYPICAL** or **AVERAGE** pain?

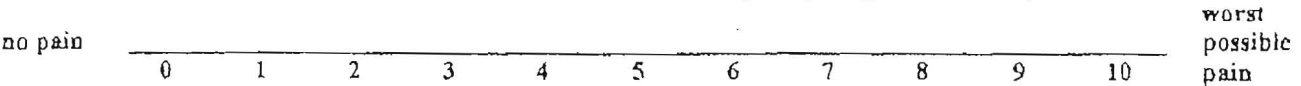


3. What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____ %

4. What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? _____ %

NAME _____ AGE _____ DATE _____ SCORE _____

SCORE: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)

VIRGINIA SPINE CARE
ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION
(“Agreement”)

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities (“payers”), which may elect or be obligated to pay benefits to me or any medical conditions, accidents, injuries, or illness, past or future (“condition”), to pay directly to and exclusively in the name of Jay Berkowitz, D.C. or “office” such sums as may be owing to the office for charges incurred by me, including but not limited to, charges for treatment, narrative reports, depositions, testimony and any other charges incurred by me at the office. I further grant a contractual lien to Jay Berkowitz, D.C. with respect to my charges; however, nothing in this Agreement shall be constructed as an election of remedies under any statutory lien law. Furthermore, in the event of a conflict between the assignment and the grant of contractual lien, the assignment shall control. For the purposes of this as any proceeds relating to commercial health or group insurance, disability benefits, worker’s compensation benefits, medical payments benefit, personal injury protection, lost wages benefit, lost service benefits, no-fault coverage, uninsured and underinsured motorists coverage, third-party liability distributions, attorney retainer agreements, and other benefit proceeds payable to me for the purposes stated herein, regardless whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay Jay Berkowitz, D.C., pursuant to this Agreement, I hereby assign, insofar as permitted by law, all of my rights, remedies and benefits to Jay Berkowitz, D.C., to the extent of my charges, as well as any and all causes of action that I might have assigned such payer, to prosecute such causes of action either in my name or in the Office name, and to settle or otherwise resolve such causes of action as the office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct each attorney to provide immediate notice of to the Office regarding any funds received by the attorney relating to my accident, to promptly pay such Office, and to provide a full accounting of such funds to the Office upon its request.

I hereby direct all payers to release to the Office any information regarding any coverage of benefits which may have included, but, not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Jay Berkowitz, D.C. to endorse/sign my name on any and all checks listing me as a payee which are presented to this Office for payment on account relating to me, my spouse or any of my dependents. I further authorize the Office to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse or my dependents, regardless of whether these other charges are related to my condition.

I understand that I have the option to consult my insurance agent or attorney before signing this form and that I am not required to execute this form to receive care. I understand that I remain personally responsible for the total amount due to Jay Berkowitz, D.C. for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. I will be responsible for payment and will reimburse Jay Berkowitz, D.C. for all costs of such collection efforts, including, but not limited to, all court costs and 33.33% attorney fees.

This Agreement shall not be modified or revoked without written consent of Dr. Jay B. Berkowitz, D.C. PC and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of Jay B. Berkowitz, D.C. PC and I. However, should any provision of this Agreement is found to be invalid, illegal or unenforceable or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall nevertheless, remain in full force and effect. (_____) Initial here that you have read or had the opportunity to read the preceding agreement.

Furthermore I acknowledge that I may consult with my insurance agent or attorney before signing this form; and that I am not required to execute this form in order to receive care.

NOTICE: Automobile accident patient

If you have been in an automobile, accident, you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this assignment of benefits form you are giving to your health care provider the right to receive some or all of that payment directly from your automobile insurance company.

If you have health insurance and your healthcare provider is in-network: as long as you provide information necessary to verify your health insurance coverage the healthcare provider may only bill the amount you owe for any copayment, coinsurance, or deductibles to your automobile insurance and you may be entitle to any remainder of your automobile insurance benefit.

If you do not provide information necessary to verify your health insurance coverage, do not have health insurance, or your healthcare provider is not in your health insurer's provider network: your healthcare provider may bill their full charges to your automobile insurance.

You may want to consult your insurance agent or attorney before signing or initialing this form. You are not required to sing/initial this form to receive care. (_____) Initial here that you have read or had the opportunity to read the preceding Notice provision.

I agree, signing as guarantor, to all these agreements, that I have read or had the opportunity to read the Notice Provision set forth above and waive notice of default in payment and prejudgment against patient

Patient Name (please print): _____

Patient Signature (parent or guardian): _____

Date _____

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Patient's Name (Print)

Patient's Signature

Date

Relationship or authority if not signed By patient

Witness

HIPPA — Notice to Patients

3/20/03

A new law has been passed by the Federal Government. The new law is called HIPPA, or Health Insurance Portability and Accountability Act. Effective immediately, there are several issues that we, as your provider, must make you aware of.

In general, HIPPA provides the first comprehensive Federal protection for the privacy of health care information, such as an individual's medical records and other personal health information, HIPPA will:

1. Give you, and only you (under the majority of cases), control over your health information.
2. Set boundaries on the use and release of health records.
3. Establish safeguards that health providers must achieve to protect the privacy of health information.

You have certain rights under HIPPA. We are obligated to inform you that you have the right to:

1. Find out how your information may be used.
2. View your file in the office. Please make an appointment for this with the front desk.
3. Have copies of your file at a charge of \$.50 per page. Please make an appointment if you wish to have copies.
4. Generally limit the release of your private information to anyone except to other providers and to anyone that is associated with your care. For example, if we refer you to a medical doctor or orthopedic doctor for your headaches, we can send them private information about you, without your authorization, so they may be able to treat you better.
5. Request corrections to your file.
6. Request us to restrict certain uses of your health information.

If you have any questions please ask and we will answer them to the best of our knowledge.

Please sign below attesting that you have read and understand the above.

Print Name: _____

Signature: _____ Date: _____

AUTOMOBILE ACCIDENT FORM

Name _____ Date of Accident _____

Was this your vehicle? Yes No State the accident happened _____

If not, who is the owner? _____

Address _____

Phone _____

Year/Make of Vehicle _____ License Tag No. _____

Name of Your Insurance Company _____

Address _____

Phone _____

Claim Number _____

Policy Number _____

Your Agent's Name _____ Has this been reported?

Year/Make of Your Vehicle _____ License Tag No. _____

Name of Driver in other vehicle _____

Phone _____

Other Driver's Insurance Company _____

Address _____

Phone _____

Claim Number _____

Policy Number _____

Their Agent's Name _____

Have you retained an Attorney? Yes No

Name _____

Address _____

Phone _____

Do you have Health Insurance? Yes No

Name of Insured _____

Name of Patient _____

Insurance Policy # _____ Group# _____

Insurance Company _____

Address _____

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident _____ Time of Accident _____ a.m.

p.m.

Please describe the accident in your own words: _____

Were you the: Driver Front Passenger Rear Passenger Pedestrian

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection with road/street _____

Driving conditions Dry Wet Icy Other _____

Which direction were you headed? _____

Speed you were traveling? _____

IMPACT

Did your car impact another vehicle? Yes No

Did your car impact a structure? Yes No

If yes, explain _____

Did any part of your body strike anything in the vehicle?

Yes No If yes, explain _____

Was impact from :

Front Rear Left Right Other _____

At the time of impact were you:

Looking straight ahead Looking to the right

Looking to the left Looking down

Looking up

Were both hands on the steering wheel? Yes No

If no, which hand was on the wheel? Right Left

Was your foot on the brake? Yes No

If yes, which foot was on the brake? Right Left

Were you: Surprised by impact Braced for impact

VEHICLE

Make and model of vehicle you were in: _____

Were you wearing a seatbelt? Yes No

If yes, what type? Lap Shoulder

Was vehicle equipped with airbags? Yes No

If yes, did it/they inflate properly? Yes No

Did your seat have a headrest? Yes No

If yes, what was the position of the headrest?

Low Midposition High

OTHER VEHICLE

(if applicable)

Make and model of other vehicle _____

Which direction was other vehicle headed? _____

Speed other vehicle was traveling _____

POLICE

Did the police come to the accident site? Yes No

Were there any witnesses? Yes No

Was a police report filed? Yes No

Was a traffic violation issued? Yes No

If yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident? Yes No If yes, for how long? _____

Please describe how you felt immediately after the accident:

TREATMENT

Did you go to the hospital? Yes No

When did you go? Immediately after accident Next day 2 days or more after the accident

How did you get to the hospital? Ambulance Private transportation

Name of hospital _____ Name of doctor _____

Diagnosis _____

Treatment received _____

X-rays taken _____

SYMPTOMS/INJURIES

Have you been able to work since this injury? Yes No How many work days have you missed? _____

Prior to the injury were you able to work on an equal basis with others your age? Yes No

If you have had any of the following symptoms since your injury, please check:

- | | | |
|--|---|--|
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Feet/toe numbness | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Neck stiff |
| <input type="checkbox"/> Back stiffness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sleep difficulty |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Ear buzzing | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Vision blurred |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea | |

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

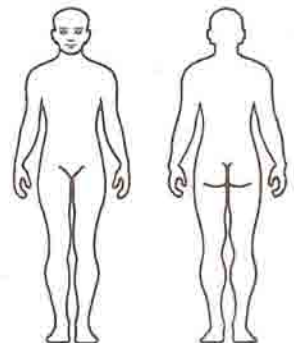
Type of pain: Sharp Dull Throbbing Numbness
 Aching Shooting Burning Tingling
 Cramps Stiffness Swelling Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking
 Bending Lying Down



I certify that the above information is correct to the best of my knowledge.

Patient Signature _____ Date _____