REGISTRATION

Carrion Chiropractic Clinic
4500 East Speedway, Suite 77
Tucson, Arizona 85712

Date_____ Home Phone_____

Patient_____
Last Name First Name Initial

Street Address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #_____ Driver's License #_____

Insured's Name_____
Last Name First Name Initial

Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other Condition Related to ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER

Company Name_____ Occupation_____

Address_____ Phone_____

City_____ State_____ Zip_____

SPOUSE

Name_____
Last Name First Name Initial

Birthdate_____ Social Security #_____

Employer Name_____ Occupation_____

Address_____ Phone_____

City_____ State_____ Zip_____

PATIENT INSURANCE INFORMATION

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

☐ MEDICARE ☐ BLUE SHIELD ☐ AUTO ACCIDENT
☐ MEDICAID ☐ MAJOR MEDICAL ☐ UNION PLAN
☐ BLUE CROSS ☐ WORKER'S COMPENSATION ☐ OTHER

BCBS I.D. # _____

MEDICARE/MEDICAID I.D. # _____

MAJOR MEDICAL OR AUTO INSURANCE Date of accident_____

Insurance Company Name_____ Adjuster_____

Address/Phone_____ Claim #_____

Policy #_____ Effective Date_____

SPOUSE CO-INSURANCE INFORMATION

~~MAJOR MEDICAL ONLY~~
Insurance Company Name_____

Address/Phone_____

Policy #_____ Effective Date_____

PATIENT AGREEMENT

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with_____
Name of Insurance Company

and assign directly to Dr._____ 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

LEGAL INFORMATION

Family Physician_____

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

_____

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PRESENT COMPLAINTS

- ☐ HEADACHE
- ☐ HEAD SEEMS TOO HEAVY
- ☐ HEAD & SHOULDERS TIRED & HEAVY
- ☐ MENTAL DULLNESS
- ☐ LOSS OF MEMORY
- ☐ EQUILIBRIUM PROBLEMS
- ☐ DIZZINESS
- ☐ FAINTING
- ☐ TREMORS
- ☐ PALPITATION
- ☐ NECK PAIN
- ☐ NECK STIFFNESS
- ☐ NECK MOTION RESTRICTED
- ☐ UPPER BACK PAIN/STIFFNESS
- ☐ MID BACK PAIN/STIFFNESS
- ☐ LOW BACK PAIN/STIFFNESS
- ☐ DIFFICULTY IN EXCESSIVE ☐ STANDING ☐ WALKING ☐ RIDING ☐ BENDING
- ☐ NECK, LOW BACK PAIN & STIFFNESS UPON RISING.
- ☐ PAIN RADIATING INTO ☐ RIGHT ARM ☐ RIGHT LEG ☐ BOTH ☐ LEFT LEG ☐ LEFT ARM ☐ BOTH
- ☐ DIFFICULTY IN EXCESSIVE LIFTING, ☐ LIGHT, ☐ MODERATE ☐ HEAVY ☐ REPETITIVE
- ☐ PAIN RADIATING INTO ☐ NECK ☐ BASE OF SKULL ☐ SHOULDER ☐ ARMS ☐ HIPS ☐ LEGS
- ☐ PINS & NEEDLES IN ARMS/LEGS
- ☐ NUMBNESS IN FINGERS, ARMS, LEGS
- ☐ CHEST PAIN
- ☐ SHORTNESS OF BREATH
- ☐ EYE STRAIN
- ☐ PAIN BEHIND EYES
- ☐ EYES SENSITIVE TO LIGHT
- ☐ EYES LOSS OF FOCUS
- ☐ DOUBLE VISION
- ☐ EARS BUZZING/RINGING
- ☐ LOSS OF TASTE
- ☐ LOSS OF SMELL
- ☐ SINUS TROUBLE
- ☐ EXTREME NERVOUSNESS
- ☐ TENSION
- ☐ IRRITABILITY
- ☐ ANXIETY
- ☐ EXTREME FATIGUE
- ☐ INSOMNIA
- ☐ NEURITIS
- ☐ FACE FLUSHED
- ☐ FACE PALE
- ☐ EXCESS PERSPIRATION
- ☐ DIGESTIVE DISORDERS
- ☐ NAUSEA, VOMITING
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ DEPRESSION
- ☐ SWOLLEN _____
- ☐ FEET/HANDS COLD
- ☐ DIFFICULTY IN PROLONGED CAR RIDING

DID YOU REQUIRE POST-ACCIDENT HOSPITALIZATION? ☐ YES ☐ NO IF SO, WHERE? _____

HAVE YOU HAD SIMILAR ACCIDENTS OR INJURIES BEFORE? ☐ YES ☐ NO

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE LAST YEAR? ☐ YES ☐ NO _____

DESCRIBE CONDITION _____ DATE OF LAST PHYSICAL EXAM _____

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ YES ☐ NO WHAT KIND? _____

ARE YOU TAKING ANY MEDICATION? ☐ YES ☐ NO WHAT KIND? _____

ARE YOU PREGNANT? ☐ YES ☐ NO DATE OF LAST MENSTRUAL PERIOD _____

Please list your symptoms below and the relative pain intensity (0 – 10) for each symptom.

No Pain 0 — Mild 1 2 3 — Moderate 4 5 6 — Severe 7 8 — Unbearable 9 10

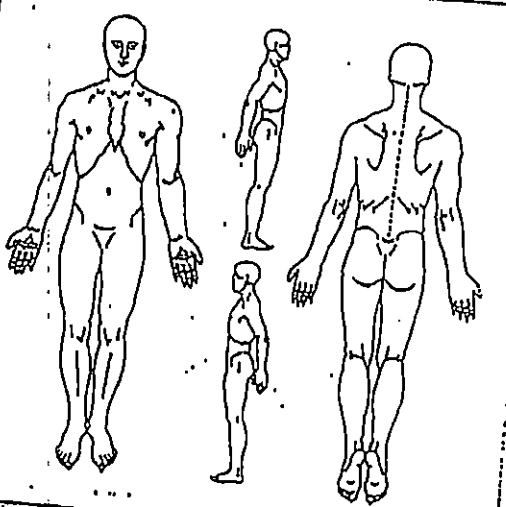
Symptoms: (*Example: Low back pain – 4*)

1) _____ 2) _____

3) _____ 4) _____

Please mark on the diagram to the right 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



Office Notes

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INFORMED CONSENT

Patient Name:_____ Date:_____

As a patient in my office, you have the legal right to know of the type of treatment we will use, any complications/side-effects, as well as alternatives to chiropractic care and their complications. This form is intended to inform you of these and treatment cannot be given until you understand these issues and sign this form. If you have any questions after reading this form, please ask me or my staff members.

The primary treatment used by doctors of chiropractic is the spinal adjustment to reduce spinal subluxations (slight dislocations or misalignments of the spinal joints). I will use that procedure to treat you as well as use other common secondary treatments such as physical therapies and modalities.

- **The nature of the chiropractic adjustment:** I will use my hands upon your spine in such a way as to move your spinal joints to restore normal joint play. This procedure may cause an audible "pop" or "click" similar to what you feel when you pop your knuckles. You may feel or sense movement of the joint, and this is usually gives you a very pleasant sense of relief. If a traditional spinal adjustment is inappropriate for your condition, there are other non-forceful types of spinal adjustments that may be used. If, from previous experiences, you prefer non-traditional types of spinal adjustments, please inform the staff beforehand.
- **The material risks inherent in a chiropractic adjustment:** While serious complications occur only 1-2 times per million adjustments, there is a slight risk, such as fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some patients will feel some stiffness or soreness following the first few days of treatment, which is considered normal.
- **The probability of those risks occurring:**
  - Fractures, especially of the ribs, are rare occurrences and generally result from some underlying weakness of the bone such as osteoporosis. If you suffer from osteoporosis, we will take special efforts to adjust your spine carefully.
  - Stroke has been the subject of tremendous disagreement within the health professions. Usually there is an underlying, pre-existing vascular condition like atherioslerosis that contributes to a stroke resulting after a neck adjustment. Some types of manipulation of the neck have been associated with other injuries to the arteries in the neck leading to a stroke in rare instances along the lines of 1 per 3 million. Mortality from spinal adjustments is 3 per 10 million.
  - Disc injuries are frequently successfully treated by chiropractic adjustments, yet occasionally chiropractic treatment may aggravate the problem and rarely surgery may become necessary if symptoms are not improved within 4 weeks. If need be, we will refer you to a neurosurgeon or for an MRI exam. These problems occur so rarely that there are no available statistics to quantify their probability.

- **Ancillary treatments:** In addition to chiropractic adjustments, I intend to use the following treatments if necessary to control your pain or to stabilize your spinal weakness:
  - Ice or hot packs: We may use both heat and ice packs, and recommend ice for home use. Both may irritate or burn your skin if over-used more than 20 to 30 minutes without a layer of clothing between your skin and the ice/heat pack. The results are temporary and occur so rarely that there are no available statistics to quantify their probability.
  - **Electro-therapy:** This modality consists of a mild electrical current which sends a massage-type action through the muscles and nerves to relax constricted muscles, to block pain impulses, to reduce swelling and to facilitate healing in muscles and ligaments. There are no known side-effects.

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- **Alternative Medical Treatments & Risks:** Other treatments are available for your condition include:
  - **Self-administered over-the-counter NSAIDs** may cause gastro-intestinal problems in 1,000 to 4,000 people per one million, and reportedly 16,500 die annually from their use.
  - **Prescription muscle relaxants and pain-killers** can produce undesirable side effects and dependence. They can also make you quite drowsy and impair your motor skills.
  - **Hospitalization and bed rest** bears the additional risk of exposure to communicable disease, loss of muscle tone and strength at the rate of 4% a day. It is also very expensive and research has shown bed rest has no benefit in helping back pain patients, in fact, it may contribute to a worsening condition.
  - Back or Neck Surgery have many risks: Infections; allergic reactions; disfiguring scar; severe loss of blood; loss of function or any limb or organ paralysis; paraplegia or quadriplegia; brain damage; cardiac arrest; death; loss of bladder, bowel or sexual function; increased or continued pain or numbness; injury to vessels in the abdomen; post-operative bleeding; injury to esophagus, trachea or lungs; hoarseness; spinal fluid leak; unstable spine requiring fusion; failure of fusion; injury to GI or GU tract; recurrence of disc problems or scar tissue formation with progressive weakness or numbness; paralysis. In addition, other risks associated with anesthesia are loss of teeth; corneal abrasions; or abdominal reactions to anesthetic agents. Serious neurological complications from neck surgery are 15,600 per million; mortality rates are 6,900 per million.

- The Risks and Dangers to Remaining Untreated:
  - Remaining untreated allows the formation of adhesions and reduces joint motion which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed. Disc degeneration, joint arthritis, nerve damage, muscular weakness and/or an increase of spinal distortions may progress if your spinal problem goes untreated.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. IF YOU HAVE UNDERSTOOD, PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic care and related treatments. I have discussed it with the doctor and/or staff of this office 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 health plan recommended. Having been informed of the nature and risks of chiropractic care, I hereby give my consent to be treated.

Name:_____ Dated:_____

Signature:_____

Signature of Parent or Guardian:_____

Witness:_____

Printed name: _____

Signature:_____

Acknowledgement and Agreement:
Patient's Protocol for Records Preservation

I, _____, patient of Dr. Carrion, do hereby acknowledge I have read and understand the doctor's protocol for the preservation of patient records. I agree to inform Dr. Carrion's office of any address changes and acknowledge that all requests for records, either by me or by my representatives, must be in writing. I agree that the doctor's office may comply with all statutory notification requirements to me by regular mail to my indicated address, which is on file at this office.

Patient Signature:_____

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