Adam L. Hendy, D.C.
1873 Williams Hwy, Ste 1B
Grants Pass, OR 97527
(541)476-0662
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ACTIVE SPORTS & FAMILY CHIROPRACTIC

Patient Registration Form

Name:_____
Last First Middle
Address:_____ City: _____ __ State: ____ Zip: _____
Mailing Address (if different): _____
Home phone #: _____ Alternate Phone #: _____
Age: _____ Date of Birth: _____ Sex: M F Social Security #:_____
Employer: _____ Work Phone: _____
Employer Address: _____
Employment Status: □ Full Time □ Part Time Student Status: □ Full Time □ Part Time
Spouse's or Parent's Name: _____
Spouse's or Parent's Employer: _____
Who should we notify in case of an emergency (Name and Number)? _____
How did you hear about our office? _____

Responsible Party:
Name of person responsible for this account: _____
Relationship to patient: _____ Phone #: _____
Address: _____ City: _____ State: ____ Zip: _____
Name of Employer: _____ Work Phone #: _____

Insurance Information:
Name of Insured: _____ Relationship to Patient: _____
Date of Birth: _____ Social Security #: _____
Insurance Company: _____Phone #: _____ Group # _____
Address: _____ City: _____ State: ____ Zip: _____

Reason For Visit:
Please tell us why you are here today: _____
_____
When and How did this injury occur: _____
_____
Have you seen any other Health Care Professional for this reason: _____
If yes, Who, and When: _____

Social History:
□ Smoking Pack/Day _____
□ Drinking Alcohol: _____
□ Coffee Cups/Day: _____
□ High Stress Reason: _____

Exercise:
□ None
□ Moderate Type: _____
□ Daily How Long; ____

Family History:

	Diabetes	Heart	Kidney	Cancer	Back
Mother	□	□	□	□	□
Father	□	□	□	□	□
Brother	□	□	□	□	□
Sister	□	□	□	□	□
Other: _____	□	□	□	□	□

To the best of my knowledge the above information is correct. I understand that any error in information may result in delay of payment. I understand that my insurance may pay less than actual charges and I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ _____
Signature of Patient (or Parent of Minor) *Date*

Please check the correct box for each item below.
Check at least one box for each sign or symptom listed.

Never Present Previous

GENERAL SYMPTOMS

☐☐☐ 905.3 Allergy (What) _____
☐☐☐ 491 Bronchitis
☐☐☐ 780.3 Convulsions
☐☐☐ 780.4 Dizziness
☐☐☐ 780.2 Fainting
☐☐☐ 780.7 Fatigue
☐☐☐ 780.6 Fever
☐☐☐ 784.0 Headache
☐☐☐ 780.52 Loss of Sleep
☐☐☐ 799.2 Nervousness
☐☐☐ 729.2 Neuralgia
☐☐☐ 780.8 Night Sweats
☐☐☐ 782 Numbness/pain in arms/legs/hands

SKIN OR ALLERGIES

☐☐☐ 690 Boils
☐☐☐ 924.9 Bruising Easily
☐☐☐ 691.8 Eczema
☐☐☐ 708.9 Hives or Allergy
☐☐☐ 782.0 Sensitive Skin
☐☐☐ 368.9 Skin Eruptions

GASTRO-INTESTINAL

☐☐☐ 787.3 Belching or Gas
☐☐☐ 789.0 Colon Trouble
☐☐☐ 783.6 Excessive Hunger
☐☐☐ 575.9 Gall Bladder Trouble
☐☐☐ 455.6 Hemorrhoids (piles)
☐☐☐ 782.4 Jaundice
☐☐☐ 794.8 Liver Trouble
☐☐☐ 787.0 Nausea
☐☐☐ 536.8 Pain over Stomach
☐☐☐ 536.8 Poor Digestion
☐☐☐ 787.0 Vomiting
☐☐☐ 578.0 Vomiting Blood

CARDIO-VASCULAR

☐☐☐ 401.9 High Blood Pressure
☐☐☐ 458.9 Low Blood Pressure
☐☐☐ 786.51 Pain over Heart
☐☐☐ 438 Previous Heart Trouble
☐☐☐ 785.0 Rapid Heart
☐☐☐ 436 Strokes
☐☐☐ 782.3 Swelling Ankles

EYE/EAR/NOSE/THROAT

☐☐☐ 493.9 Asthma
☐☐☐ 389.9 Deafness
☐☐☐ 388.60 Ear Discharge
☐☐☐ 388.3 Ear Noises
☐☐☐ 240.9 Enlarged Thyroid
☐☐☐ 460 Frequent Colds
☐☐☐ 784.49 Hoarseness
☐☐☐ 478.1 Nasal Obstruction
☐☐☐ 784.7 Nose Bleeds
☐☐☐ 379.91 Pain in Eyes
☐☐☐ 473.9 Sinusitis
☐☐☐ 463 Tonsillitis

MUSCLES & JOINTS

☐☐☐ 550.0 Hernia
☐☐☐ 719.1 Pain Between Shoulders
☐☐☐ 724.6 Painful Tailbone
☐☐☐ 781.9 Spinal Curvature
☐☐☐ 719.0 Swollen Joints
☐☐☐ 781.0 Tremors
☐☐☐ 781.0 Twitching

Never Present Previous

RESPIRATORY

☐☐☐ 786.50 Chest Pain
☐☐☐ 786.09 Difficulty Breathing
☐☐☐ 786.3 Spitting Blood
☐☐☐ 786.4 Spitting Phlegm

GENITO-URINARY

☐☐☐ 599.7 Blood in Urine
☐☐☐ 788.4 Frequent Urination
☐☐☐ 788.3 Inability to Control Urine
☐☐☐ 590.9 Kidney Infection
☐☐☐ 788.1 Painful Urination
☐☐☐ 601.9 Prostate Problems

FOR WOMEN ONLY

☐☐☐ 625.3 Cramps or Backaches
☐☐☐ 627.2 Hot Flashes
☐☐☐ 626.4 Irregular Cycle
☐ Yes ☐ No Currently Pregnant
_____ Due Date
_____ Last Pap Date

OPERATIONS AND PROCEDURES

	DATE		DATE		DATE
Vaccinations	_____	Tubes in Ears	_____	Sinus	_____
Tonsillectomy	_____	Appendectomy	_____	Hernia	_____
Gall Bladder	_____	Female Organs	_____	Thyroid	_____
Back Surgery	_____	Rectal Surgery	_____	Stomach	_____

Other: _____

☐ **None. I have never had any operations / surgeries**

List any accidents or falls and dates: ☐ Car: _____ ☐ Recreation Vehicle: _____
☐ Sports: _____ ☐School: _____ ☐ Other: _____
List any broken bones (fractures) or dislocations: _____
Ever on crutches? ☐ Yes ☐ No Why? _____
Have you ever had any spinal taps or spinal injections? ☐ Yes ☐ No Were you ever knocked unconscious? ☐ Yes ☐ No
Have you ever had a lapse of memory? ☐ Yes ☐ No
Have you ever had X-rays taken? ☐ Yes ☐ No When? _____ By Whom? _____
For what ailments were these X-rays made? _____
Do you suffer from any condition other than that for which you are now consulting us? _____
Are you presently taking any medication – prescription or over the counter? ☐ No ☐ Yes What drugs? _____
_____
What other factors of your health have you not revealed perhaps because you are embarrassed by them, if any? _____
_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account or receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I HAVE READ AND UNDERSTAND THE ABOVE

Patient's/Guardian's Signature: _____ Date: _____

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Informed Consent

I, the undersigned, have voluntarily requested that Dr. Adam L. Hendy assist me in the management of my health concerns. I understand and agree to all policies and terms provided in the Office Policies and Procedures.

Chiropractic healthcare is an art and science that is primarily concerned with the relationship between structure (primarily of the spine) and function (primarily of the nervous system). The doctor of chiropractic evaluates the patient using standard examination and testing procedures (such as orthopedic and neurologic evaluation and possibly x-rays). The chiropractic examination focuses on structural or functional abnormalities called "subluxation" or Segmental Dysfunction. Subluxation or Segmental Dysfunction exists when one or more vertebrae in the spine or bones in the extremity are fixated sufficiently to result in damage or irritation to either nearby nerves, joints, and or tissues such as muscles and ligaments. The primary goal of chiropractic treatment is to remove the subluxation or Segmental Dysfucntion. This is accomplished by performing a procedure unique to chiropractic called an adjustment. An adjustment involved the application of a quick, precise force directed over a very short distance to a specific vertebrae or bone. Adjustments are usually performed by hand, but may use a hand-guided instrument. In addition to adjustments, other treatments used by chiropractors include physiotherapy modalities (ice, heat, soft tissue manipulation, motor nerve stimulation), nutritional recommendations and rehabilitative procedures.

As is the case with all health care interventions, the benefits of care must be weighted against the inherent risks and limitations of receiving treatment. Chiropractic treatments are one of the safest interventions available to the public as evidenced by malpractice statistics. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Nonetheless, they must be considered when making the decision on whether or not to receive chiropractic care. Listed below are summaries of some key research articles that have addressed treatment results and common and rare side-effects/complications associated with chiropractic care.

Results from Treatment

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Possible Risks & Side Effects from Treatment

One research study indicated that within the first 2 months of care, approximately half of patients report some "reaction" to chiropractic treatment. Of those who reported a reaction, the following were the most commonly reported reactions to initial chiropractic care:

- Local Discomfort (53%)
- Headache (12%)
- Tiredness (11%)
- Radiating Discomfort (10%)

Most appeared within 4 hours of treatment and resolved within 24 hours.

Rare, yet possible side-effects / Complications:

- Rib Fracture
- Disc Herniation
- Cauda Equina Syndrome (1 case per 100 million adjustments)
- Compromise of the vertebrobasilar artery (ie. Stroke) (1 case per 400,000 to 1 million cervical spine adjustments)

A thorough health history and physical examination will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including:

Medications: I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks that I should discuss with my medical doctor.

Rest/Exercise: Simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for conditions such as joint instability or serious disk rupture, among others. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

Please answer all questions below to help us determine possible risk factors:

1. Have you ever had an adverse (ie. bad) reaction to or following chiropractic care Y N
2. Have you ever been diagnosed with osteoporosis? Y N
3. Do you take corticosteroids (ie. Prednisone)? Y N
4. Have you ever been diagnosed with a compression fracture of the spine? Y N
5. Have you ever been diagnosed with cancer? Y N
6. Have you recently had an unexplainable loss of weight? Y N
7. Do you take Warfarin (coumadin), heparin or other "blood thinners"? Y N
8. Have you ever had a stroke or TIA (transient ischemic attack)? Y N
9. If you have a complaint of neck pain or headache is this unlike anything you've ever experienced before? Y N
10. Have you ever been diagnosed with any of the following?
    a. Rheumatoid Arthritis Y N
    b. Reiter's Syndrome, Ankylosing Spondylitis, Psoriatic Arthritis Y N
    c. Giant Cell Arteritis Y N
    d. Ligamentous Hypermobility (Marfan's, Ehler's Danlos) Y N
11. Have you ever become dizzy while turning your head? Y N
12. Have you ever had spinal surgery? Y N
13. Have you ever been diagnosed with spinal stenosis? Y N
14. Have you ever had any of the following problems? Y N
    a. Sudden weakness in the arms of legs? Y N
    b. Numbness in the genital area? Y N
    c. Recent inability to urinate or lack of control when urinating? Y N

I have read or have had read to me the above explanation of chiropractic treatment. The doctor has also asked me if I want a more detailed explanation; but I am satisfied with the explanation and do not want any further information. I have made my decision voluntarily and freely. To attest to my consent to these examination and treatment procedures, I hereby affix my signature to this Informed Consent document.

Signature of patient (or guardian) _____ Date _____

I explained the procedures, alternatives, and risks in conference with the patient.

Doctor's Signature _____ Date _____

NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you (as a patient of Active Sports and family Chiropractic) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (**IIHI**). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may us and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Active Sports and Family Chiropractic
Adam Hendy, D.C.
1873 Williams Hwy, Suite 1B
Grants Pass, OR 97527
(541)476-0662

C. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice – including, but not limited to, our doctors, or indirectly with any provider we refer you to – may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.
4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organs and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation in you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for worker's compensation and similar programs.

HIPAA Privacy Practices – Patient Reception Form

I have received or reviewed the privacy practice notice for Active Sports and Family Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially initiated care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____

Patient Signature Date

_____

Print Patient Name