KEY TO LIFE CHIROPRACTIC

REGISTRATION FORM

Date _____ Home Phone _____ Cell Phone _____

Email _____

Last Name _____ First Name _____ Middle Initial __

Street Address _____

City _____ State _____ Zip _____

Sex M____ F____ Birth Date _____ Occupation _____

How did you hear about this office? _____

CONSENT TO INITIATE CARE

At our office, we have one simple goal – we want to render the highest quality Chiropractic care at the lowest possible fee. In order to accomplish this goal, we have altered some of our business procedures to keep our fees reduced. Please read over these procedures below to understand how our office functions, and to decide if you wish to participate. If you have any questions, please direct them to the receptionist.

- You may choose to submit receipts to your insurance company or other third-party health care programs, but payment for such services by insurance companies is neither implied nor agreed to by this office. We take *no responsibility* for non-payment by insurance companies for services rendered at our office.
- Our office will not respond to any requests for paperwork for insurance purposes or even acknowledge insurance requests for information on any patient's case. However, patients may have a copy of their records at any time they request.
- No balances can be kept or run by patients at any time.
- All visits are paid the same day the service is rendered, or prepaid.
- Our office reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served.

I wish to initiate care at this office. I have read and understand the Consent to Initiate Care and agree to all terms. I understand that I am under no obligation to receive or continue care.

Print Your Name _____ Today's Date _____

Sign Your Name _____

PARENTAL CONSENT TO EVALUATE AND TREAT A MINOR

I _____, being the parent/legal guardian

of _____ hereby grant permission for my

child to receive chiropractic care. Witness Signature: _____

(Office Staff Only)

SOME QUESTIONS TO HELP US HELP YOU

NAME: _____ DATE: _____

If we could help you with only one health problem, what would it be? _____

_____

What other health problem would you like us to help you with? _____

_____

_____

How did these problems start? _____

_____

_____

When did these problems begin? _____

Have you ever had these problems before? _____

Is it worse in the morning or at night? (check one) Morning _____ or Night _____

Do you ever have numbness, tingling or pain in the arms or legs? _____

How often do you feel the pain and how long does it last? _____

Please list any other doctors seen for the above problem: _____

Please list medications you are currently taking: _____

_____

Please list any surgeries you have had: _____

_____

Please list any auto or work injuries you have had: _____

_____

Please circle any in your family history: -Heart disease -Diabetes -Arthritis

-Cancer -Back problems

Do you get dizziness? Yes or No Do you have heart, lung or stomach problems? Yes or No

Are you right or left-handed? _____ How tall are you? _____ How little do you weigh?_____

Name of previous chiropractor: _____

Are you looking for temporary relief or do you want the cause of your problem fully corrected?
_____ Why? _____

What activities or hobbies have you been unable to do because of your problem? _____

_____

NAME: _____

Please mark the areas on the drawings where you have pain. Be as specific as you can. Include all affected areas.

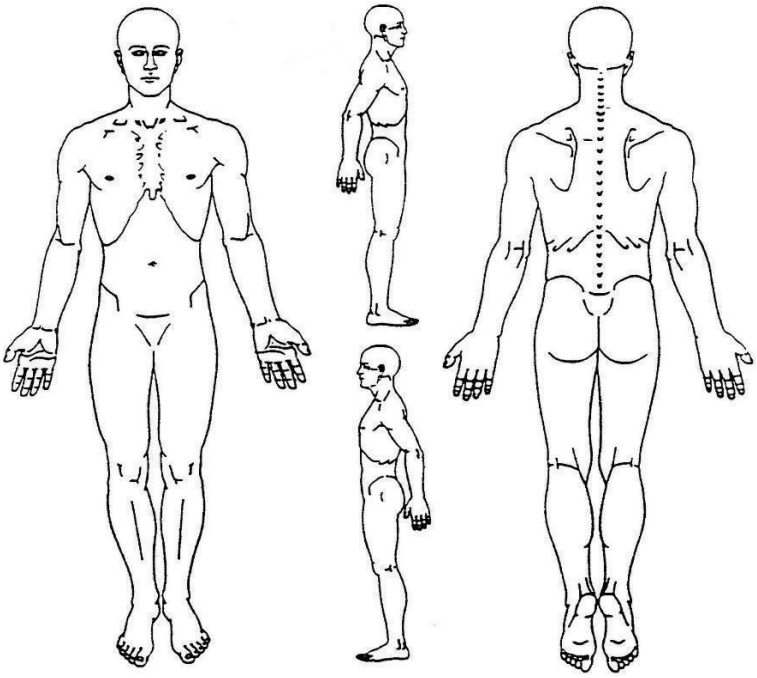
Rate your pain today.

Circle the appropriate number on the pain scale below. If zero, perfect, you are here for wellness care. Congratulations!

If 10, we need to get you to the ER.

PAIN SCALE

0—1—2—3—4—5—6—7—8—9—10



PLEASE CHECK ANY OF THE FOLLOWING WHICH YOU ARE EXPERIENCING TODAY

GASTRO-INTESTINAL SYSTEM

____Poor appetite
____Excessive hunger
____Difficult chewing
____Excessive thirst
____Difficult swallowing
____Nausea
____Vomiting food
____Vomiting blood
____Abdominal pain
____Diarrhea
____Constipation
____Black stool
____Bloody stool
____Hemorrhoids
____Liver trouble
____Gall bladder problem
____Weight trouble

GENITO-URINARY SYSTEM

____Bladder trouble
____Excessive urination
____Scanty urination
____Painful urination
____Discolored urine

NERVOUS SYSTEM

____Numbness
____Loss of feeling
____Paralysis
____Dizziness
____Fainting
____Headaches
____Muscle jerking
____Convulsions
____Forgetfulness
____Confusion
____Depression

CARDIO-VASCULAR RESPIRATORY

____Chest Pain
____Pain over heart
____Difficult breathing
____Persistent cough
____Coughing phlegm
____Coughing blood
____Rapid heartbeat
____Blood pressure problem
____Heart problems
____Lung problems
____Varicose veins

MUSCULO-SKELETAL SYSTEM

____Low back problems
____Pain between shoulders
____Neck Problems
____Arm problems
____Leg problems
____Swollen joints
____Painful joints
____Stiff joints
____Sore muscles
____Weak muscles
____Walking problems
____Ruptures
____Broken bones

FEMALE

____Vaginal discharge
____Vaginal bleeding
____Vaginal pain
____Breast pain
____Lumps on breast

ARE YOU PREGNANT?
____Yes ____No

EYE,EAR,NOSE,THROAT

____Eye strain
____Eye inflammation
____Vision problems
____Ear pain
____Ear noises
____Hearing loss
____Ear discharge
____Nose pain
____Nose discharge
____Difficulty breathing through nose
____Sore gums
____Dental problems
____Sore mouth
____Sore throat
____Hoarseness
____Difficult speech

PURPOSE OF AN ADJUSTMENT DISCLOSURE

By signing below, I acknowledge that I understand that chiropractic care is given to correct misalignments of the spine called SUBLUXATIONS. One of the benefits of a chiropractic adjustment is that you MAY feel better but this is not the goal of an adjustment. The GOAL of an adjustment is to correct SUBLUXATIONS, thereby removing the interference to the nervous system allowing the body to heal itself. As a result, WE DO NOT TREAT PAIN OR DISEASE; we remove subluxations so that the body is able to function properly and be better enabled to heal itself.

INSURANCE AND INJURY NOTICE

I am aware that Key to Life Chiropractic and Dr. Wayne Christianson do not provide care for work related injuries, automobile accident injuries, or personal injuries. I also acknowledge that I must inform this office of any injuries sustained. I also am completely aware that Key to Life Chiropractic and Dr. Wayne Christianson, WILL NOT; bill, submit claims, nor prepare or submit reports for any insurance claims of any kind.

I also understand that I must inform this office if I have Medicare coverage and I understand that I am responsible to pay for each visit myself at the time of service.

Signed: _____ Date: _____

Please Print Patient Name: _____

Relationship to Patient: _____

KEY TO LIFE CHIROPRACTIC

Orientation Questionnaire

1. What controls and coordinates all the functions in your body? _____
2. What is it called when the spine is misaligned? V_____S_____
3. Is the purpose of an adjustment to make the body Heal better or Feel better? (circle one)
4. Do Chiropractors: Adjust subluxations or Treat pain? (circle one)
5. What are 3 ways a Chiropractor can find a vertebral subluxation _____
   _____
6. What causes a Subluxation? _____
7. How often does the research show we should be checked for subluxations?
   _____
8. Name 4 things you can do to keep you and your family healthy:
   _____ Well, _____ Well, _____ Well and Stay Well _____

I _____ have watched the online orientation and understand the purpose of chiropractic and how often to be checked for vertebral subluxations in the office.

Signed_____

Date_____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures.

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____	_____	_____
Printed Name	**Signature**	**Date**

WITNESS:

_____	_____	_____
Printed Name	**Signature**	**Date**
(Office Staff Only)		