



PATIENT REGISTRATION FORM

CONFIDENTIAL PATIENT INFORMATION				
Last Name:	First Name:	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.
Social Security:	Birth Date:	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other:		Spouse's Name:		
Street Address:		Email Address:		
City:	State:	Zip:	Country:	
Home Phone:	Mobile Phone:	Occupation:		
Employer:	Employer Address:		Work Phone:	
Family Medical Dr.:		Previous Chiropractor:		
Referred by: <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Internet <input type="checkbox"/> Other:				
<input type="checkbox"/> Patient Name:		<input type="checkbox"/> Dr's Name:		
Emergency Contact:		Relationship:	Home Phone:	Alt Phone:

INSURANCE INFORMATION			
Subscriber's Name:	Birth Date: (if diff)	Phone: (if diff)	SSN#: (if diff)
Address: (if diff)	City:	State:	Zip:
Primary Insurance Type: <input type="checkbox"/> Self Pay <input type="checkbox"/> Medicare <input type="checkbox"/> Auto Accident <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Other health insurance carrier			
Carrier Name:		Group No.:	Policy No.:
Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/> Other			

I certify that the above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize HEALTH SOLUTIONS or my insurance company to release any information necessary to process my claims.

Patient/Guardian Signature

Date



HEALTH PROFILE

Our goal is to address the issues which brought you to HEALTH SOLUTIONS, and to offer you the opportunity for improved health and wellness in the future. Answering the following questions will assist us in identifying the specific stresses you have faced in your lifetime, allowing us to better assess and address the challenges to your health potential.

Do you experience any of these health problems?

- | | |
|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Stressed Shoulders | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Loss of Energy |
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Mid-Back Pain | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Leg & Hip Pain | <input type="checkbox"/> Frequent Cold/Flu |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Sinus Pain or Allergies |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Wrist Pain |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Heart Palpitation |
| <input type="checkbox"/> Stress | |

Describe your current symptoms:

When did your symptoms start?

How did your symptoms begin?

Is this due to an accident or injury?
 Yes No Date: _____

Type of accident: Auto Work Home
 Other:

How often do you experience your symptoms?

- | | |
|--|--|
| <input type="checkbox"/> Constantly (76-100% of the day) | <input type="checkbox"/> Occasionally (26-50% of the day) |
| <input type="checkbox"/> Frequently (51-75% of the day) | <input type="checkbox"/> Intermittently (0-25% of the day) |

What describes the nature of your symptoms?

- Sharp Dull ache Numb Shooting Burning Tingling Stabbing

On a scale of 1-10 (1 being none, 10 being unbearable), please rate the average intensity of your symptoms over the last 4 weeks:

Is this condition interfering with your: Work Daily routine Sleep Social activities
 Other:

Please rate your overall health:
 Excellent Good Fair Poor

What are your symptoms affected by:
 Sitting Standing Bending Lifting
 Walking Laying down

Have you experienced similar symptoms in the past?
 Yes No

Has the problem been getting:
 Better Worse Staying the same

Who have you seen for your symptoms?

- No one Another Chiropractor Medical Physician Physical Therapist

Name of Physician/Chiropractor:

What methods have you previously tried?

- Exercise Massage Acupuncture Physical Therapy Chiropractic Prescription Drugs

HEALTH PROFILE CONTINUED		
Do you suffer from any of the following: (please check all that apply)		
<input type="checkbox"/> alcoholism	<input type="checkbox"/> ears, nose, throat problems	<input type="checkbox"/> migraines
<input type="checkbox"/> anemia	<input type="checkbox"/> emphysema	<input type="checkbox"/> multiple sclerosis
<input type="checkbox"/> arthritis	<input type="checkbox"/> epilepsy or convulsions	<input type="checkbox"/> neurological problems
<input type="checkbox"/> asthma	<input type="checkbox"/> eye problems	<input type="checkbox"/> numbness
<input type="checkbox"/> blood pressure problems	<input type="checkbox"/> fatigue/low energy	<input type="checkbox"/> obesity
<input type="checkbox"/> cancer	<input type="checkbox"/> fibromyalgia	<input type="checkbox"/> osteoporosis
<input type="checkbox"/> chronic fatigue	<input type="checkbox"/> glaucoma	<input type="checkbox"/> scoliosis
<input type="checkbox"/> circulatory problems	<input type="checkbox"/> heart disease	<input type="checkbox"/> seasonal affective disorder
<input type="checkbox"/> cholesterol issues	<input type="checkbox"/> infection, chronic	<input type="checkbox"/> sexually transmitted disease
<input type="checkbox"/> depression	<input type="checkbox"/> irritable bowel syndrome	<input type="checkbox"/> sinus problems
<input type="checkbox"/> diabetes	<input type="checkbox"/> kidney or bladder disease	<input type="checkbox"/> stroke
<input type="checkbox"/> digestive problems	<input type="checkbox"/> liver or gallbladder disease	<input type="checkbox"/> thyroid problems
<input type="checkbox"/> drug addiction	<input type="checkbox"/> loss of balance	<input type="checkbox"/> ulcer
<input type="checkbox"/> eating disorder	<input type="checkbox"/> mental illness	<input type="checkbox"/> urinary tract infection
Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No How often?	Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No Packs/day:	Drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Drinks/week:
Do you consume caffeine/coffee? <input type="checkbox"/> Yes <input type="checkbox"/> No Cups/day:	<i>For women only</i> Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Allergies:		
Past Surgeries:		
Past Injuries:		
Medications:		
Supplements:		

This is to certify that to the best of my knowledge I am not pregnant and the medical staff of HEALTH SOLUTIONS has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ *Patient Signature*

_____ *Date*



FAMILY HEALTH HISTORY						
	Mother Age:	Father Age:	Brother Age(s):	Sister Age(s):	Spouse Age:	Children Age(s):
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back/Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia/Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pinched Nerve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus/Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If any of the above family members are deceased, please list their age at death and cause of death:

Mother:	Age at death:	Cause:
Father:	Age at death:	Cause:
Brother(s):	Age at death:	Cause:
	Age at death:	Cause:
	Age at death:	Cause:
Sister(s):	Age at death:	Cause:
	Age at death:	Cause:
	Age at death:	Cause:
Children:	Age at death:	Cause:
	Age at death:	Cause:
	Age at death:	Cause:
Spouse:	Age at death:	Cause:



INFORMED CONSENT FORM

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Our chiropractic method of correction is by specific adjustments of the spine. We do not offer diagnosis or treatment of any disease. We only offer to diagnose either vertebral subluxations or neuromusculoskeletal conditions. However, during the course of a chiropractic spinal examination, if we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to expression of the body’s innate wisdom. Our only method is specific adjustments to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

The undersigned patient hereby requests and consents to examination and analysis by Dr. Caroline Bergeron and staff at HEALTH SOLUTIONS. This request includes, but is not limited to, permission for Dr. Bergeron, his associates and staff to perform structural and neurological evaluations and adjustments based primarily in NUCCA’s protocol as may be determined appropriate by them.

The undersigned patient understands that Dr. Bergeron has concentrated her practice on the NUCCA technique in chiropractic care. Adjustments are only given when a misalignment at the top of the spinal chord is detected. Adjustments are not necessarily given on every office visit. Since an adjustment uses very little depth, the patient feels very little, if any, force.

NUCCA treatment does not address all aspects of health. I understand that Dr. Bergeron strongly recommends that I obtain regular examinations from my personal medial physician for overall diagnosis and care of conditions the may not be due to or respond to NUCCA techniques.

The risks and possible consequences of adjustments and the possibility of complications have been explained to me. I acknowledge that no guarantee or assurance has been given by anyone as a result of the adjustments. I am aware that success of any case depends on factors beyond the control of the chiropractor including compliance by the patient with all instructions and directions.

I, _____, have read and understand this INFORMED CONSENT and have had the opportunity to ask questions concerning this form and possible care. I accept care on this basis.

Patient Signature

Date

I, _____, being the parent or legal guardian of _____ have read and understand this INFORMED CONSENT and have had the opportunity to ask questions concerning this form and possible care. I hereby grant permission for my child to receive care on this basis.

Guardian Signature

Date



NOTICE OF PRIVACY POLICY

HEALTH SOLUTIONS is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices.

Disclosure of Health Care Information:

Disclosure of your protected health information without authorization is strictly limited to defined situations that include health care, quality assurance activities, payment, worker's compensation, deceased persons, public health and safety, research, and law enforcement activities. Any other disclosures for the purpose of treatment or practice operations will be made only after obtaining your consent.

Treatment Facilities:

Our office has four treatment rooms, two that are open and two that have the option of a closed door. The open rooms do not provide much privacy, therefore, patients in the next room or staff walking in the hallway could hear your conversation with the doctor and your private healthcare information could be overheard. If you wish for more privacy, please notify us and other arrangements can be made.

Sign-in Sheets:

Our sign in sheets are located in plain view at the front desk. The only information provided on this sheet is your name, appointment date and time. No other personal information is provided. If you prefer not to sign in, you must notify the front desk verbally that you are here.

Testimonials:

We display patient testimonial books on the tables in the reception area. You have the option of signing your name on the testimonial form. Please be aware that if you sign your name, anyone entering the office has access to read the testimonial books.

Emergencies:

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition in the event of an emergency. This contact person should be listed on the patient information form.

Change of Ownership:

In the event that HEALTH SOLUTIONS is sold or merged with another organization, your health information/record will become the property of the new owner.

Appointment Reminder Notices or Messages:

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.



Your Rights:

- ◆ You may request restrictions on your disclosures. Be advised that HEALTH SOLUTIONS is not required to agree to the restrictions that you have requested.
- ◆ You have the right to have your health information received or communicated through an alternative method or sent to an alternate location other than the usual method of communication or delivery, upon your request.
- ◆ You have the right to inspect a copy of your medical information.
- ◆ You have the right to request that HEALTH SOLUTIONS amend your protected health information. Be advised that HEALTH SOLUTIONS is not required to agree to amend you protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of the reason(s) for the denial and information about how you can disagree with the denial.
- ◆ You have the right to receive an accounting of disclosures of your protected health information made by HEALTH SOLUTIONS.
- ◆ You have the right to a paper copy of this notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Policy:

HEALTH SOLUTIONS reserves the right to amend this Notice of Privacy Policy at any time in the future, and will make the new provision(s) effective for all information that it maintains. Until such amendment is made, HEALTH SOLUTIONS is required by law to comply with this notice.

If you have any questions or complaints about any part of this notice, or if you want more information about your privacy rights, please contact Dr. Caroline Bergeron by calling this office at 847-329-7501.

If you are not satisfied with the manner in which this office handles your complaints, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509 HHH Building
Washington, DC 20201

I have read and understand my rights contained in this Notice. By way of my signature, I provide HEALTH SOLUTIONS with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in this Notice.

Patient’s Name (Print): _____

Relationship to Patient (if not patient): _____

Signature: _____ Date: _____