



Dr. Kelli Brown, D.C.
114 S. Iowa Avenue • Washington, IA 52353

◆ REGISTRATION INFORMATION ◆

PLEASE PRINT AND FILL IN COMPLETELY

PATIENT INFORMATION:

First Name _____ Middle Initial _____ Last Name _____

Preferred Name _____ Social Security Number _____

Home Phone _____ Cell Phone _____

Street Address _____ City _____ State _____ Zip _____

Sex Male Female Birthdate _____ Age _____ E-Mail Address _____

Single Married Widowed Divorced Employed Retired

Full-Time Student Part-Time Student ~ School _____

Employer _____ Occupation _____ Phone: _____

Employer Address _____ City _____ State _____ Zip _____

SPOUSE OR GUARDIAN (IF CHILD) INFORMATION:

First Name _____ Middle Initial _____ Last Name _____

Social Security Number _____ Birthdate _____

Home Phone _____ Street Address _____

City _____ State _____ Zip _____

Employer _____ Occupation _____ Phone: _____

Employer Address _____ City _____ State _____ Zip _____

Emergency Contact Person _____

Phone _____ **Relationship to Patient** _____

How did you hear about us? Referred by _____ KCII Radio__ Local paper__
Yellowpages__ Online__

Assignment and Release

I assign directly to Dr. Kelli L. Brown, D.C. all medical benefits, if any, otherwise payable to me for the 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 whether manual or electronic. Furthermore, I authorize the release of my medical records to secure payment and/or to receive medical information pertaining to my case in this facility.

Signature of Insured/Guardian

Date

Authorization for Chiropractic Treatment

I hereby authorize Dr. Kelli L. Brown, D.C. and the staff of Brown Chiropractic Clinic to perform diagnostic tests and render care considered therapeutically necessary on the basis of findings during the course of my treatment. As of the date stated below, I have the legal right to select and authorize health care services for the patient named above. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify Brown Chiropractic Clinic.

I hereby certify that I have read and fully understand the above Authorization for Chiropractic Treatment. I also certify that no guarantee or assurance has been made as to the results that may be attained.

Patient or Guardian Signature

Date

Privacy Statement

In general, the HIPAA privacy rule gives individuals the right to request confidential communications or that a communication of private health information be made by alternative means, such as sending correspondence to the patient's office instead of their home. Occasionally our office will send out greeting cards, reminder postcards, call you regarding an appointment, etc. Please let us know which form(s) of communication you would prefer to be contacted by. By signing this form, I am acknowledging that I have been notified of the Privacy Practices utilized in this office. I may be contacted in the following manner (check all that apply):

Home Telephone _____

- O.K. to leave message with detailed information
- Leave message with call-back number only

Work Telephone _____

- O.K. to leave message with detailed information
- Leave message with call-back number only

Cell Telephone _____

- O.K. to leave message with detailed information
- Leave message with call-back number only

Written Communication

- O.K. to mail to my home address
- O.K. to mail to my work/office address
- O.K. to fax to this number _____
- O.K. to e-mail to _____

Other _____

Patient or Guardian Signature

Relationship to Patient

Witness

Date

CHIROPRACTIC HEALTH QUESTIONNAIRE

Date _____

Patient name _____ Birthdate _____

Reason for visit _____

Have you been treated before for this problem? No Yes

If yes, by Physician Doctor of Chiropractic Physical Therapist Osteopath Other _____

What did they do and/or recommend? _____

When did your symptoms appear? _____ Is this condition getting progressively worse? Yes No Unknown

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 Walking Bending Lying down Other _____

Your Occupation _____ Non-job exercise _____ hrs/wk

Have you ever had chiropractic care for other problems? No Yes If yes, when and what problem? _____

Do you take Muscle relaxers Pain killers Insulin Birth control pills Over-the-counter meds Other prescription drugs

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 _____

Name of your Medical Doctor _____

Do you wear Heel lifts Shoe lifts Arch supports Orthotics, describe _____

GENERAL SYMPTOMS Check symptoms you currently have or have had in the past.

AIDS	Cataracts	Hepatitis	Mumps	Suicide attempt
Alcoholism	Chemical dependency	Hernia	Osteoporosis	Thyroid problems
Anemia	Chicken pox	Herpes	Pacemaker	Tonsillitis
Anorexia	Diabetes	High cholesterol	Pneumonia	Tuberculosis
Appendicitis	Emphysema	HIV positive	Polio	Tumors, growths
Arthritis	Epilepsy	Kidney disease	Prostate problem	Typhoid fever
Asthma	Fractures	Liver disease	Prosthesis	Ulcers
Bleeding disorders	Glaucoma	Measles	Psychiatric care	Vaginal infections
Breast lump	Goiter	Migraine headaches	Rheumatoid arthritis	Venereal disease
Bronchitis	Gonorrhea	Miscarriage	Rheumatic fever	Whooping cough
Bulimia	Gout	Mononucleosis	Scarlet fever	Other _____
Cancer	Heart disease	Multiple sclerosis	Stroke	

MEDICATIONS List medications you are currently taking **VITAMINS/HERBS/MINERALS**

_____ _____ _____ Allergies _____	_____ _____ _____ _____
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SURGERIES List surgeries and approximate dates **TRAUMAS** List traumas and approximate dates

_____ _____	_____ _____
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GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	WOMEN ONLY
Bruise easily	Appetite poor	Bleeding gums	Abnormal pap smear
Chills	Bloating	Blurred vision	Bleeding between periods
Dental problems	Bowel changes	Crossed eyes	Breast lump
Depression	Constipation	Difficulty swallowing	Extreme menstrual pain
Difficulty sleeping	Diarrhea	Double vision	Hot flashes
Dizziness	Excessive hunger	Earache	Other _____
Fainting	Gas	Ear discharge	Date of last period _____
Fever	Hemorrhoids	Hay fever	Date of last Pap Smear _____
Forgetfulness	Indigestion	Hoarseness	Have you had a
Headache	Nausea	Loss of hearing	Mammogram? _____
Loss of sleep	Rectal bleeding	Nosebleeds	Are you pregnant? _____
Nervousness	Stomach pain	Persistent cough	Number of children _____
Numbness	Vomiting	Ringling in ears	
Sweats	Vomiting blood	Sinus problems	
Tiredness	CARDIOVASCULAR	Vision-flashes	
Weight gain/loss	Chest pain	Vision-halos	
GENITO-URINARY	High blood pressure	SKIN	
Blood in urine	Low blood pressure	Bruise easily	
Frequent urination	Irregular heart beat	Hives	
Lack of bladder control	Poor circulation	Itching	
Painful urination	Rapid heart beat	Change in moles	
	Swelling of ankles	Rash	
	Varicose veins	Scars	

NECK, BACK, EXTREMITIES

NECK	MID-BACK continued	LOW BACK continued
Pain in neck	Pain from front to back	Low back feels out of place
Neck stiffness	Muscle spasms in mid-back	Muscle spasms in low back
Neck weakness	ARMS & HANDS	HIPS, LEGS, FEET
Pinched nerve in neck	Right Left	Right Left
Neck feels out of place	Pain in upper arm R L	Pain in buttocks R L
Muscle spasms in neck	Pain in elbow R L	Pain in hip joint R L
Grinding/popping sounds in neck	Pain in forearm R L	Pain down leg R L
SHOULDERS	Pain in hand R L	Pain in knee R L
Right Left	Pain in fingers R L	Pain in ankle R L
Pain in shoulder joint R L	Pins/needles in arm R L	Pain in foot R L
Pain across shoulders	Pins/needles in finger R L	Weakness of leg R L
Can't raise arm R L	Numbness in arm R L	Weakness of ankle R L
Above shoulder level	Numbness in fingers R L	Leg cramps R L
Over head	Weakness of arm R L	OTHER SYMPTOMS
Tension in shoulders	Weakness of hand R L	_____
Pinched nerve in shoulder R L	Hands cold R L	_____
MID-BACK	LOW BACK	_____
Mid-back pain	Low back pain	_____
Mid-back stiffness	Low back stiffness	_____
Pain between shoulder blades	Low back weakness	_____
	Pinched nerve in low back	_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Date _____

Reviewed by _____ Date _____