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_____

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_____

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

Brown Chiropractic Clinic ♦ 114 S. Iowa Avenue ♦Washington, IA 52353 ♦ (319) 653-3336

office use_____

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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_____	_____

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

GENERAL
- Bruise easily
- Chills
- Dental problems
- Depression
- Difficulty sleeping
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Nervousness
- Numbness
- Sweats
- Tiredness
- Weight gain/loss

GENITO-URINARY
- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

GASTROINTESTINAL
- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

CARDIOVASCULAR
- Chest pain
- High blood pressure
- Low blood pressure
- Irregular heart beat
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT
- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision-flashes
- Vision-halos

SKIN
- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars

WOMEN ONLY
- Abnormal pap smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Other

Date of last period _____

Date of last Pap Smear_____

Have you had a Mammogram?_____

Are you pregnant? _____

Number of children_____

NECK, BACK, EXTREMITIES

NECK
- Pain in neck
- Neck stiffness
- Neck weakness
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding/popping sounds in neck

SHOULDERS	**Right**	**Left**
Pain in shoulder joint	R	L
Pain across shoulders		
Can't raise arm	R	L
Above shoulder level		
Over head		
Tension in shoulders		
Pinched nerve in shoulder	R	L

MID-BACK
- Mid-back pain
- Mid-back stiffness
- Pain between shoulder blades

MID-BACK continued
- Pain from front to back
- Muscle spasms in mid-back

ARMS & HANDS	**Right**	**Left**
Pain in upper arm	R	L
Pain in elbow	R	L
Pain in forearm	R	L
Pain in hand	R	L
Pain in fingers	R	L
Pins/needles in arm	R	L
Pins/needles in finger	R	L
Numbness in arm	R	L
Numbness in fingers	R	L
Weakness of arm	R	L
Weakness of hand	R	L
Hands cold	R	L

LOW BACK
- Low back pain
- Low back stiffness
- Low back weakness
- Pinched nerve in low back

LOW BACK continued
- Low back feels out of place
- Muscle spasms in low back

HIPS, LEGS, FEET	Right	Left
Pain in buttocks	R	L
Pain in hip joint	R	L
Pain down leg	R	L
Pain in knee	R	L
Pain in ankle	R	L
Pain in foot	R	L
Weakness of leg	R	L
Weakness of ankle	R	L
Leg cramps	R	L

OTHER SYMPTOMS

_____
_____
_____
_____
_____
_____
_____
_____

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_____

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