CONNECTED CHIROPRACTIC
Dr. Michael Marchese

6821 N Country Homes Blvd – STE 204
Spokane, WA 208
(P) 509- 818-1811

Chiropractic Registration

Patient Information:

Name: _____

Sex: ☐ Male ☐ Female **DOB**: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Email: _____

Marital Status: ☐ Married ☐Single ☐ Other

Referred By: _____

Contact Information:

Cell Number: _____

Home Number: _____

Text Message Reminders: ☐ Yes ☐ No

Emergency Contact:

Name: _____ **Relation**: _____

Contact Number: _____

Can your account or health information be discussed with this person: ☐Yes ☐ No

Insurance Information:

Billing Insurance: ☐ Yes ☐ No

Insurance Company: _____

Account Responsibility: ☐Myself ☐ Other

Responsible Party (if other): _____

Insurance / Financial Assignment:

I certify that I – or a dependent have insurance coverage with the above listed insurance company and assign directly to Connected Chiropractic all benefits. The above doctor/clinic and its legal representatives may use and disclose my health information to the above-named insurance company (or future insurance companies) for use of obtaining payment or benefit information.

I understand I am responsible for all financial charges regardless of insurance coverage, claim decision, or non-payment by my insurance company. I authorize the use of my electronic signature on all insurance submission forms. If prior authorization is required on my policy, it is my responsibility to obtain this information before treatment is rendered.

Cancellation Policy:

Appointments canceled with less than 24 hour notice may be subject to a $50 fee. This fee is not billable to insurance and is non transferable.

Patient Signature: _____ Date: _____

Accident Information:

Is your current condition due to an accident: ☐ Yes ☐ No
(If answer is no – leave remainder of Accident Information Blank)

Type of Accident: ☐ Auto ☐ Work **Date of Accident**: _____

Accident Reported To: ☐ Auto Insurance ☐ Employer ☐ Workers Compensation

Attorney Name (if applicable): _____

Condition:

When did your symptoms start: _____

Area(s) of Complaint: ☐ Neck ☐ Middle Back ☐ Low Back ☐ Left Shoulder ☐ Right Shoulder ☐ Left Hip ☐ Right Hip ☐ Headaches ☐ Migraines ☐ Wellness / Preventative

Do you have radiating symptoms: ☐ Yes ☐ No --- Where: ☐ Left Arm ☐ Right Arm ☐Left Leg ☐ Right Leg

Would you describe symptoms as: ☐ Dull / Achy ☐ Sharp / Stabbing ☐ Burning ☐ Stiff / Tight ☐ Numb

Frequency of Symptoms: ☐ Constant (100%) ☐ Frequent (75%) ☐ Occasional (50%) ☐ Intermittent (25%)

Do these symptoms affect your: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Recreational Activities -- ☐ ALL

What aggravates your symptoms: ☐ Sitting ☐ Standing ☐ Bending ☐ Twisting ☐ Lifting ☐ Walking ☐ Exercise ☐ Sleeping ☐ Sneezing/Coughing ☐ Driving ☐ Other: _____

What makes your symptoms better: ☐ Rest ☐ Ice ☐ Heat ☐ Stretching ☐ Medication ☐ Topical Creams

Who have you seen for this condition: ☐ MD/ PCP ☐ Acupuncture ☐ PT ☐ Massage ☐ None

Prior Chiropractic Care: ☐ Yes ☐ No --- If yes, when: _____

Have you had spinal x-rays within the last 5 years: ☐ Yes ☐ No

Goals for care: ☐ Short Term Symptom Relief ☐ Correction and Stabilization ☐ Other: _____

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Health History:

Have you ever had any of the following:

Alcoholism	☐ Yes ☐ No	**Bulimia**	☐ Yes ☐ No	**High BP**	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	**Cancer**	☐ Yes ☐ No	**Kidney Disease**	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	**Depression**	☐ Yes ☐ No	**Liver Disease**	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	**Diabetes**	☐ Yes ☐ No	**Migraines**	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	**Disc Issues**	☐ Yes ☐ No	**Osteoporosis**	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	**Epilepsy**	☐ Yes ☐ No	**Pinched Nerve**	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	**Fractures**	☐ Yes ☐ No	**Prosthetics**	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	**Heart Disease**	☐ Yes ☐ No	**Seizers**	☐ Yes ☐ No
Auto Immune	☐ Yes ☐ No	**Hernia**	☐ Yes ☐ No	**Stroke**	☐ Yes ☐ No

Are you currently taking any prescription medication: ☐ Yes ☐ No

Name of Medication: _____ **Used to Treat:** _____

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Name of Medication: _____ **Used to Treat:** _____

☐ **Medication list provided to staff**

Surgeries:

Have you ever had spinal surgery: ☐ Yes ☐ No

Have you ever had joint replacement surgery: ☐ Yes ☐ No

Family History:

Auto Immune Disorders: ☐ Parents ☐ Siblings ☐ Grandparents ☐ None

Cancer: ☐ Parents ☐ Siblings ☐ Grandparents ☐ None

Heart Disease: ☐ Parents ☐ Siblings ☐ Grandparents ☐ None

Neurological Disorders ☐ Parents ☐ Siblings ☐ Grandparents ☐ None

Stroke: ☐ Parents ☐ Siblings ☐ Grandparents ☐ ☐ None

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INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of therapy, modalities, and if necessary diagnostic x-rays (performed outside clinic).

I further understand that such chiropractic services may be performed by the Doctor of Chiropractic at this office on me now, or in the future. I have had the opportunity to discuss the nature and purpose of chiropractic adjustments, and other procedures, with the provider, and I understand that results are not guaranteed.

I understand there are possible risks associated with treatment. Including, but not limited to: fracture, disc injury, stroke (CVA), dislocations, and sprains. I do not expect the provider to be able to anticipate and explain all risks or complications associated with treatment. Further, I wish to rely on the provider to exercise judgment during the course of treatment - to which the provider feels are in my best interest at the time.

I have read, or have had read to me, the above consent. I have also had opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommendations by my provider. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility, now and in the future.

_____
Print Patient Name

_____ _____
Signature of Patient Date Signed

SIGN BELOW ONLY IF PROVIDING CONSENT FOR SOMEONE OTHER THAN YOURSELF

_____
Print Name of Legal Representative

_____ _____
Signature of Legal Representative Date Signed