

CONFIDENTIAL REGISTRATION FORM

Please Print

Today's Date ___/___/___

PATIENT INFORMATION

Patient's Last Name		First	Middle Int.	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	<input type="checkbox"/> Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid
Social Security No.	Home Phone No. ()	Cell Phone No. ()		Birth Date / /	Age Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address		City	State	Zip Code	Email Address
Occupation	Employer			Work Phone No. () ext.	
The best place to contact me is (circle one): Home Work Cell Email					
Whom may we thank for referring you? <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital <input type="checkbox"/> Location					
<input type="checkbox"/> Patient _____ <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Internet Search/Yellow Pages					
<input type="checkbox"/> Family/Friend _____ <input type="checkbox"/> Other _____					
Family Doctor	Family Doctor Address or City			Family Doctor Phone ()	

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone No. ()	Cell Phone No. ()
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PATIENT CONDITION / HISTORY

Reason for your visit today? _____

When did your symptoms FIRST appear? _____ What do you believe caused your symptoms? _____

Are the injuries/conditions you are seeking treatment for related to an open auto accident, personal injury or worker's compensation claim? YES NO **If yes, please inform the front desk before treatment is initiated.*

Imaging performed for your symptoms X-rays (date) _____ MRI (date) _____ Other (date) _____

Please list any medications or supplements you are taking: _____

Smoking _____ pack(s) a day for _____ year(s) Alcohol _____ drinks per week
 Caffeine Drinks _____ cups per day High Stress? Reason: _____

What is your exercise level? None Moderate Daily Heavy Type: _____
 How is your health?: Good Fair Poor Are you under a doctor's care presently? No Yes, for: _____

Severe Trauma/Head Injuries: _____ Date: _____
 Auto Accident Injuries: _____ Date: _____
 Fractures/Dislocations: _____ Date: _____
 Recent or Major Surgeries: _____ Date: _____
 Previously Diagnosed Conditions (such as: Osteoporosis / Heart Disease / High Blood Pressure / Diabetes / Cancer) _____

Please list any allergies: _____

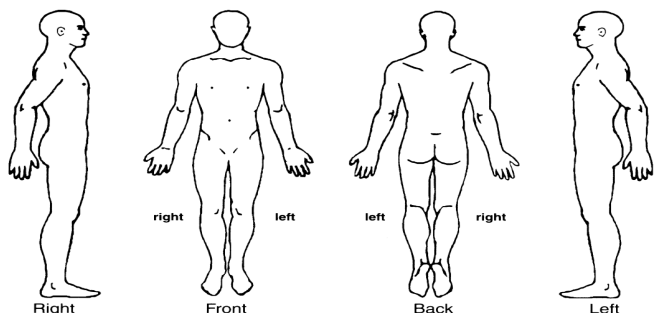
Have you or any relatives ever suffered a stroke? Yes No Last Full Physical Examination (Date) _____

PAIN DIAGRAM

Please indicate where you are experiencing pain

A = ACHE B = BURNING N = NUMBNESS
 P = PINS & NEEDLES S = SHARP O = OTHER

On a scale of 1 to 10, what is your current pain level?
 0 1 2 3 4 5 6 7 8 9 10 circle one
 (0 is no pain, 10 is the worst pain imaginable)



WEB EXERCISES / ONLINE REHABILITATION PROGRAM / EMAIL OPT-IN

Our office utilizes WebExercises to assist in our home care. Studies show recovery times are shorter when participating in a home exercise program.

Instead of using out of date, printed exercise forms with small pictures and short descriptions, our office utilizes the newest and up to date software that allows you to review you exercise program simply by accessing your email.

The software also allows you to watch full videos of how to specifically perform each exercise/stretch and your treating doctor has full access to fine tune the specifics of your program at any time.

Be assured that you will not receive any unsolicited email from either us or WebExercises.

In order to participate please choose the appropriate option.

Yes, I would like to utilize the online home exercise program, if/when a program is necessary for care

If you choose this option please enter the email address you'd like your program sent to: _____

I would prefer to receive the exercise handouts only.

CANCELLATIONS AND NO-SHOWS

Cancellations - Our office policy requires a 24 hour notice for appointment cancellations or rescheduling. We typically have a waiting list of patients who would like to see the doctors. If you cannot make your appointment, please extend the office and other patients the courtesy of giving ample notice so that someone on the waiting list may be seen during that time.

No-Shows - We understand that things do come up and we will try to be as accommodating as possible. But please be aware that a \$25 fee will be assessed for no-shows and cancellations without a 24 hour notice.

I understand and accept this policy.

Patient Signature

Date

CONSENT FOR USE OF PHI FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (HIPPA)

I consent to the use or disclosure of my protected health information (PHI) by Active Spine & Sport Therapy for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Brian C. Mulhall DC, Janson Kemp DC or J. Neil Dukas DC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Active Spine & Sport Therapy is not required to agree to the restrictions that I may request. However, if Active Spine & Sport Therapy agrees to a restriction that I request, the restriction is binding on Active Spine & Sport Therapy.

I have the right to revoke this consent, in writing, at any time, except to the extent that Active Spine & Sport Therapy has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Active Spine & Sport Therapy's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the clinic. The Notice of Privacy Practices for Active Spine & Sport Therapy is posted in the reception area. This Notice of Privacy Practices also describes my rights and Active Spine & Sport Therapy's duties with respect to my protected health information.

Active Spine & Sport Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Signature

Printed Name

Date

Informed Consent to Physical Medicine, Joint Manipulation and Manual Therapy

Please read this entire document prior to signing. It is important that you understand the information it contains. Please feel free to ask questions and to review any information if anything is unclear.

- As part of your analysis, examination and treatment, you are consenting to the following procedures

Spinal Manipulative Therapy	Extremity Joint Manipulation	Range of Motion/Neurological Testing
Muscle Strength Testing	Orthopedic Testing	Motion Palpation
Muscular Palpation	Vital Signs	Active Release Techniques (ART)
Electrical Stimulation Therapy	Ultrasound Therapy	Radiographic Studies
Hot/Cold Therapy	Postural Analysis	Kinesio Taping Therapy
Myofascial Release Therapy	Trigger Point Therapy	McKenzie Evaluation/Treatment
- The material risk inherent in Active Release Techniques/Myofascial Release Therapy

Active Release Techniques (ART) is a hands-on soft tissue treatment method. You will physically move the region of the body getting worked on through active ranges of motion. ART may be uncomfortable in some regions of the body (like the burn experienced while lifting weights) and may produce soreness post-treatment for up to 1-3 days.
- The material risk inherent in McKenzie Mechanical Diagnosis and Therapy/ Active Therapeutic Movement (ATM2)

McKenzie Mechanical Diagnosis and Therapy is a diagnostic and therapeutic system used to identify and treat spinal and extremity conditions based on identifying the patient's initial baselines (symptoms, mechanical and neurological deficits) and then introducing progressive and specific load to the area in question and observing any changes made to the initial baselines. Through observation and testing, a reductive movement/load can be identified that produces noted and drastic improvements to the patient's symptoms and mechanical and neurological deficits. Through the testing procedures, patients may experience temporary stiffness and strain while performing some of the specific loading strategies that commonly last 10-15 minutes but can last up to 1-2 days. Active Therapeutic Movement (ATM2) is a new therapeutic system that utilizes patient positioning and support/bracing to allow patients to actively move against resistance throughout movement patterns that were once painful in order to retrain muscular tone, reduce spasm and restore range of motion. In doing so, some patients become muscularly sore at first after performing the resistance work for 12-48 hours. This soreness is very rare and minimal when present.
- The nature of spinal/extremity joint manipulation

After a full evaluation of your condition, the doctor may make the decision that manipulative therapy would be beneficial to assist your recovery. If joint manipulation is used, the doctor would use his hands in such a way as to move your joints to restore range of motion, proper function and reduce the perception of pain. You may feel a click or pop, similar to someone cracking their knuckles, and you may feel movement of the joint.
- The material risk inherent in joint manipulative therapy and ancillary procedures

As with any health care procedure, there are certain complications which may arise following joint manipulation therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscular strain or cervical myelopathy. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke. Some patients will feel some soreness and stiffness following the first twenty four to forty eight hours following their first and/or second treatment utilizing joint manipulation. Your doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to his attention, it is your responsibility to inform him.
- The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which is checked for during the taking of your history and during examination and x-ray. Stroke has been a subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical manipulations. The other complications are also described as rare.
- The availability and nature of other treatment options

Other treatment options for your condition may include: Self administered, over-the-counter analgesics and rest; Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; Hospitalization or Surgery. If you chose to use one of the other treatment options, you should be aware that there are risks and benefits of such options and you may wish to discuss those with your primary care physician or specialist.
- Procedures you would like excluded from your treatment

If there are any procedures previously listed that you would explicitly request not to be employed in your treatment please list these below. We will gladly employ other treatment options to in an attempt to reach the same results.
- The risks of and dangers of remaining untreated

Remaining untreated may allow the formation of adhesions and reduced mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Patient Signature

Date