REGISTRATION FORM

Today's Date: ____________________ NEW CLIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name First Middle Int.	Ms. Mr. Mrs. Miss Dr.	Single D.Prtnr Mar. Wid. Sep. Div.

Preferred Name:	Preferred Phone:	Birth Date / /	Age	Sex M F

Street Address City State Zip	Best E-mail:

Occupation	Employer	Employer Phone No. ( ) - ext.

The best place to contact me is (*circle one)*: Cell Personal E-mail

Whom may we thank for referring you? Please write the name and address of the person referring you.

Patient ______________________________ Dr. ______________________________ Insurance Plan Hospital

Family Member/Friend ____________________ Internet ______ Close to home/work Other ________________

Primary Care Physician (PCP):	PCP Address:	PCP Phone: ( ) -

May we inform your PCP about your treatment? Yes No

IN CASE OF AN EMERGENCY

Name of Local Friend or Relative:	Relationship to Patient:	Cell Phone No. ( ) -	Work Phone No. ( ) -

PATIENT CONDITION

Describe your symptoms. When and how did they begin?

How many times have you had these symptoms before?

Never 1 – 2 3 – 4 5 – 7 More than 7

What activities and/or movements make your symptoms better or worse?
Better: Worse:

Are your symptoms:

Sharp Dull Burning Tingling Numb Shooting Pain Where? __________________________

Cramps Stiffness Swelling Throbbing Other: ____

How bad are your symptoms? 0 = no pain 10 = unbearable pain

At their worst: 1 2 3 4 5 6 7 8 9 10 At their best: 1 2 3 4 5 6 7 8 9 10

How much of the day do you experience your symptoms?

(76 – 100%) (51 – 75%) (26 – 50%) (0 – 25%)

What time of the day is the pain at its worst?

Morning, on arising Late in the morning Afternoon Evening

Bedtime Night (disturbs sleep) Pain is always the same Pain varies, no particular time.

How do your symptoms affect your ability to perform your daily activities?

No effect Mild, forgotten with activity Moderate, interferes with activity Limiting, prevents full activity
Intense, always seeking relief No activity possible

Have you received treatment for the same condition in the past? Yes No
If "yes," what type of treatment did you receive? Chiropractic care Other: ____________________________________
What tests, if any, were performed? X-Ray(Date) ________ MRI(Date) ________ CT(Date) __________
Other _________________________

Are you currently seeing other health/wellness specialists? (Doctor, Massage Therapist, Personal Trainer, Acupuncturist, Dietician)

May we contact any individuals listed above? Yes No

REGISTRATION FORM

PATIENT HISTORY

Previous Auto Accidents or Trauma?

Injuries/Surgeries you have had:

Description Date(s)

Falls: ____

Head Injuries: ____

Fractures: ____

Broken Bones: ____

Dislocations: ____

Surgeries: ____

Habits:

Smoking: ______ pack(s)/day for ____ year(s)

Alcohol: ______ drinks per week

Caffeine Drinks: ______ cups per day

High Stress Level: Reason: ______________________

Exercise level within the last 6 months?

None **Type:**

1-2 times per week

3-5 times per week

Daily

Have you been diagnosed or been told you have any of the following? (*Please check all that apply*)

AIDS/HIV; date ___________________

Cancer: __________________________

Headaches

Organ Disease: ___________________

Heart condition: __________________

Diabetes: Type I or Type II

Osteoporosis

Hardening of the arteries

Epilepsy

Eating Disorder: ___________________

Neurologic Disease: ______________

Heart or blood vessel disease

Bone spurs

Blood in stool/urine

Anemia

Herniated disc: ___________________

Hypertension

Stroke

Whiplash

Pacemaker

Blurred vision/Double vision

Tumors or Growths: ______________

Psychiatric Care: ________________

Addictions: _____________________

Sexually Transmitted Disease: _____

Other: _________________________

____

Have you had any of the following symptoms for even a short period during the past year? (*Please check all that apply*)

Dizziness

Ringing in ears

Hearing Loss

Loss of bowel/bladder control

Abdominal pain/pulsations

Difficulty swallowing

Slurred speech or other speech problems

Persistent cough

Diminished or partial loss of vision

Temporary lack of understanding

Numbness or loss of sensation in the face, arms, hands, fingers or legs

Any other abnormal or loss of sensation in another body part

Weakness, clumsiness or strength loss in the face, arms, hands, fingers or legs

Unexplained weight loss

Loss of consciousness

Sudden collapse without loss of consciousness

Other: ____

Are you under a doctor's care presently for any type of health problem? Yes No

If "yes," please explain: ____

What, if any, diseases run in your family?

Have any relatives ever suffered a stroke? Yes No If "yes," who? ______________________________________

Please list any allergies:

Please list any Medications your are currently taking:

Please list Vitamins/Supplements you are currently taking:

MEN ONLY

Difficulty with urination? Yes No

Excessive urination? Yes No

Date of last prostate exam: ______________ Never

History of prostate problems? Yes No

WOMEN ONLY

Do you take birth control pills? Yes No

If "yes," how long? _____________

Date of last period: _____________

Do you experience any of the following:

Menstrual pain

Cramping

Irregularity

History of vaginal infections

Are you pregnant? Yes No

If "yes," due date: ________________

# of Births: _______ Type: _______

REGISTRATION FORM

<u>I hereby authorize Chicago Integrative Movement Specialists to perform an evaluation and to administer whatever treatment is deemed clinically necessary . _______________ *(initial)*</u>**

Benefits and Risks:
Participants in a regular and integrated program of manual therapy, proper nutrition, physical activity and scientific supplementation (where applicable) have been shown to produce positive metabolic changes in human physiology. These changes include: decreased body fat, increased work capacity and vitality, improved cardiovascular efficiency, increased muscular strength, flexibility, power and endurance.

I recognize and understand fully that the strategies recommended to me by CIMS pertaining to manual therapies/nutrition/exercise/supplementation may or may not work well for me as everyone is created differently and individual results may vary. I understand that I have ultimate control over whatever strategy I decide to implement throughout my involvement with CIMS and the recommended training program. I also recognize that exercise carries some risk to the musculoskeletal system (sprains/strains) and the cardio-respiratory system (dizziness, discomfort breathing, heart attack). I hereby certify that I know of no medical problem (except those noted in the health history form attached hereto) that would increase my risk of illness or injury as a result of participating in the training program.

By signing this consent form, I understand that I am personally responsible for my actions during my health and/or fitness program and my association with CIMS. Furthermore, I waive the responsibility of CIMS if I should incur any injury as a result of my negligence.

I certify that I have read and do understand the above financial obligations #1-5. I agree to be responsible for payment of all services rendered on my behalf or that of my dependent according to the above terms.

<u>Your signature is necessary before any treatment or advice may be rendered.</u>

Patient Signature: ____ Date: ___________

Guardian Signature: ____ Date: ___________

<u>REQUIRED FORM : Patient Authorization to Charge a Credit Card</u>

(MasterCard, Discover, Visa and AMEX are accepted)

______	**On-going charges:** Please bill all charges incurred for professional services to my credit card beginning on ____/____/____. I understand that any such charges will be made as they are incurred. <u>THIS INCLUDES LATE CANCELLATION CHARGES.</u> Cancellation charges will ONLY occur when a cancellation is received ***<u>within 24 business hours</u>*** (Monday-Friday) of scheduled appointment and CIMS is unable to accommodate another patient with the appointment. *The fees are:* Chiropractic: 1st cancellation \$50.00; subsequent cancellations \$70.00. Personal Fitness, Massage Therapy and Manual Therapy are billed at 100%. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. If there is any unpaid balance, it will be charged to my credit card.

Credit Card #: ______________________________________ Expires: ____/______

Mailing Address Zip: _______________ Security Code: (found on back of card): _______

Signature: ____

Printed Name: ____

Please email a copies of the receipt to:

____

REGISTRATION FORM

Receipts for all credit card transactions are emailed within 7 days of transaction.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY AND SIGN AT THE BOTTOM.

Dr. Osar and CIMS are required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of legal duties and privacy practice with respect to your protected health information.

Disclosure of Health Care Information
Treatment: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

Payment: We may disclose your health information to your insurance provide for the purpose of payment or healthcare operations.

Workers' Compensation: We may disclose your health information as necessary to comply with State Workers' compensations laws.

Emergencies: We may disclose your health information to notify or assist in notifying an immediate family member or other person responsible for your care, about your medical condition in the event of an emergency or your death.

Public Health: As required by law, we may disclose your health information to the public health authorities for purpose related to preventing or controlling disease. Injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the FDA problems with products and reactions to medications and reporting disease or infection exposure.

Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement: We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, or other law enforcement policies.

Deceased Persons: We may disclose your health information to coroners or medical examiners in the event of your death.

Organ Donation: We may disclose your health information to organizations involved in procuring, banking, and transplanting organs/tissues.

Research: We may disclose your health information to researchers conducting studies that has been approved by an Institutional Review Board.

Public Safety: It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health and safety of a particular person or the general public.

Specialized Government Agencies: We may disclose your health information for military, national security, prisoner and government benefits purposes.

Phone Messages/Emails: We may contact you for office affairs and appointments.

Change of Ownership: In the event that Dr. Osar and CIMS are sold/merged with another organization, your health information/record will become property of the new owner.

Your Health Information Right

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Dr. Osar and CIMS are not required to agree to the restrictions that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery. This request must be in writing, signed by you, and list and limitations.
- You have the right to inspect and request a copy of your health information. Any copy of your file will be delivered within a reasonable time to you or the party that you designate as a recipient on forms available in our office.
- You have a right to request that Dr. Osar and CIMS amend your protected health information. Please be advised, however, that Dr. Osar and CIMS are not required to agree to amend your protected health information. If your request is denied, you will be provided with an explanation.
- You have a right to receive an accounting of disclosures of your protected health information made by Dr. Osar and CIMS.
- You have a right to a paper copy of this Notice of Privacy Practices at anytime upon request.

Changes to this Notice of Privacy Practices
Dr. Osar and CIMS reserve the right to amend this Notice of Privacy Practice at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, Dr. Osar and CIMS are required by law to comply with this notice. Dr. Osar and CIMS are required by law to maintain the privacy if your health information and to provide you with notice of their legal duties and privacy practices with respect to your health information. If you have any questions about any part of this notice or if you want more information about your privacy rights, please contact our office.

Complaints
Complaints about your privacy rights of how CIMS has handled your health information should be directed to Dr. Osar. If you were not satisfied with the manner in which Dr. Osar or CIMS handles your complaint, you may submit a formal complaint to the Office of Civil Rights.

This Notice is effective as of _____/______/______
I have read the Notice of Privacy Practices and understand my rights contained in the notice. By signing below, I provide Dr. Osar and CIMS with my authorization and consent to use and to disclose my protected healthcare information for the purposes of treatment, payment and healthcare operations as described above.

Patient's Name (Printed):____

Patient Signature/Guardian's Signature:____ Date:____________________

Authorized Facility Signature:____ Date:____________________