AURORA CHIROPRACTIC CLINIC RICHARD ROGERS B.S., DC
1571 AURORA ROAD . MELBOURNE, FL 32935 .321-254-9060

PATIENT REGISTRATION & HISTORY

DATE_____

NAME _____AGE_____ DATE OF BIRTH_____

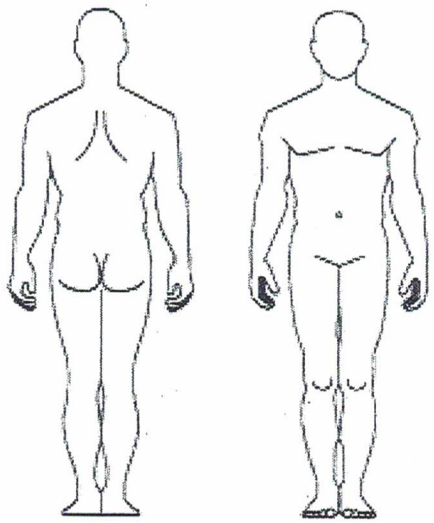
ADDRESS_____CITY_____STATE_____ZIP_____
SS#_____MARITIAL STATUS_____ EMAIL_____
HOME PHONE_____CELL_____WORK_____
OCCUPATION_____EMPLOYER_____
FAMILY PHYSICIAN_____EMERGENCY CONTACT NAME & PHONE_____
WHOM MAY WE THANK FOR REFERRING YOU?_____
WHAT ARE YOUR CURRENT SYMPTOMS?_____
WHEN DID THE SYMPTONS FIRST APPEAR?_____

PAIN LEVEL (1=LEAST PAIN AND 10=MOST PAIN) 1 2 3 4 5 6 7 8 9 10

TYPE OF PAIN (**PLEASE CIRCLE**) SHARP DULL THROBBING NUMBNESS ACHING SHOOTING BURNING CRAMPS TINGLING STIFFNESS SWELLING OTHER_____ HOW OFTEN DOES PAIN OCCUR?_____
DOES THE PAIN INTERFERE WITH YOUR ACTIVITIES (**PLEASE CIRCLE**) WORK SLEEP DAILY ROUTINE RECREATION
PAINFUL TO PERFORM MOVEMENTS (**PLEASE CIRCLE**) SITTING STANDING WALKING BENDING LYING DOWN

HAVE YOU HAD XRAYS, MRI, CT OR OTHER IMAGING STUDIES IN THE PAST 5 YEARS? YES NO
IF SO, WHAT TYPE OF IMAGING STUDY AND WHEN_____

PLEASE CIRCLE THE AREA OF CONCERN FOR YOUR APPOINTMENT TODAY



NAME_____ DATE_____

HEALTH HISTORY

HAVE YOU HAD ANY TREATMENT FOR THIS PROBLEM IN THE PAST? YES NO

IF SO, BY WHOM AND WHEN _____

MEDICATIONS _____

VITAMINS/HERBS/MINERALS _____

ALLERGIES _____

SURGERIES_____

PLEASE CIRCLE TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

AIDS /HIV	ALCOHOLISM	ALLERGY SHOTS	ANEMIA
ANOREXIA	APPENDICITIS	ARTHRITIS	ASTHMA
BLEEDING DISORDERS	BREAST LUMP	BRONCHITIS	BULIMIA
CANCER	CATARACTS	CHEMICAL DEPENDENCY	CHICKEN POX
DIABETES	EMPHYSEMA	EPILEPSY	FRACTURES
GLAUCOMA	COITER	GONORRHEA	GOUT
HEART DISEASE	HEPATITIS	HERNIA	HERNIATED DISC
HERPES	HIGH BLOOD PRESSURE	HIGH CHOLESTEROL	KIDNEY DISEASE
LIVER DISEASE	MEASLES	MIGRAINES	MISCARRIAGE
MONONUCLEOSIS	MUMPS	OSTEOPOROSIS	PACEMAKER
PARKINSON'S DISEASE	PINCHED NERVE	PNEMONIA	POLIO
PROSTATE PROBLEM	PROSTHESIS	PSYCHIATRIC CARE	RHEMATOID ARTHRITIS
RHEUMATIC FEVER	SCARLET FEVER	STROKE	SUICIDE ATTEMPT
THYROID PROBLEMS	TONSILLITIS	TUBERCULOSIS	TUMORS, GROWTHS
TYPHOID FEVER	ULCERS	VAGINAL INFECTIONS	VENEREAL DISEASE
WHOOPING COUGH	OTHER_____		

EXERCISE (**PLEASE CIRCLE**) NONE MODERATE DAILY HEAVY

WORK ACTIVITY (**PLEASE CIRCLE**) SITTING STANDING LIGHT LABOR HEAVY LABOR

HABITS (**PLEASE CIRCLE**)

SMOKING (PACKS PER DAY) _____ ALCOHOL (DRINKS PER WEEK) _____

CAFFEINATED DRINKS (CUPS PER DAY) _____ HIGH STRESS LEVEL (REASON) _____

ARE YOU PREGNANT? YES NO DUE DATE _____

FAMILY HISTORY

MOM-AGE MEDICAL PROBLEMS _____

DAD-AGE MEDICAL PROBLEMS_____

SIBLINGS-AGE MEDICAL PROBLEMS_____

INSURANCE INFORMATION

WAS THIS INJURY DUE TO AN AUTO ACCIDENT? (**PLEASE CIRCLE**) YES NO DATE_____
WAS THIS AN ON-THE-JOB INJURY? (**PLEASE CIRCLE**) . YES NO DATE_____
WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____RELATIONSHIP TO PATIENT_____
INSURANCE COMPANY_____ POLICY NUMBER_____

ASSIGNMENT AND RELEASE

I CERTIFY THAT I AND/OR MY DEPENDENTS HAVE COVERAGE WITH THE ABOVE-NAMED INSURANCE COMPANY AND ASSIGN DIRECTLY TO DR. RICHARD ROGERS AT AURORA CHIROPRACTIC CLINIC ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO DR. RICHARD ROGERS FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. AURORA CHIROPRACTIC CLINIC MAY USE MY HEALTH CARE INFORMATION AND DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY AND THEIR AGENTS FOR THE PURPOSE OF OBTANING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

x_____

PATIENT/REPRESENTATIVE SIGNATURE DATE

_____

PRINT NAME RELATIONSHIP TO PATIENT

NAME_____ DATE_____

AURORA CHIROPRACTIC CLINIC
DR. RICHARD S. ROGERS CHIROPRACTIC PHYSICIAN
1571 AURORA ROAD MELBOURNE, FL 32935 321-254-1744

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: **I have had the following unusual risks of my case explained to me.**
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____	_____	_____
Printed Name	**Signature**	**Date**

WITNESS:

_____	_____	_____
Printed Name	**Signature**	**Date**