2001 Crocker Rd. #100
Westlake, OH 44145

The Drugless Doctors • 440.471.4200 • druglessdrs.com

PRACTICE MEMBER REGISTRATION FORM

FILE #:_____

NAME			**HOME #**	
ADDRESS			**CELL/WORK #**	
CITY/STATE/ZIP			**E-MAIL**	
EMERGENCY CONTACT & PHONE	**SPOUSE NAME**		**NAMES & AGES OF CHILDREN**	
○ **MALE** ○ **FEMALE**	○ **Single** ○ **Married** ○ **Divorced** ○ **Widowed**	**DATE OF BIRTH**	**REFERRED BY**	**PRIVATE PHYSICIAN**
PREFERRED METHOD OF CONTACT: EMAIL TEXT **CELLULAR PROVIDER:**		****You may receive an automatic text and/or email appointment reminder. Please notify the staff if you do not want to receive this.**		

PLEASE INDICATE REGION OF COMPLAINT

○ **HEADACHES** ○ **NECK PAIN**
○ **UPPER BACK** ○ **MID BACK** ○ **LOW BACK**
○ **SHOULDER** ○ **ELBOW** ○ **WRIST** ○ **HAND**
○ **HIP** ○ **KNEE** ○ **ANKLE** ○ **FOOT PAIN**
○ **OTHER** ***explain:***

PLEASE DESCRIBE YOUR SYMPTOMS INCLUDING ONSET DATE
_____

PLEASE RATE YOUR PAIN: 0 1 2 3 4 5 6 7 8 9 10
No Pain Severe Pain

PLEASE DESCRIBE YOUR PAIN:
○ Sharp ○ Dull ○ Shooting ○ Burning ○ Throbbing ○ Numb ○ Tingling

HOW LONG DOES PAIN PERSIST? _____

IT IS: ○ **CONSTANT** ***76-100%*** ○ **FREQUENT** ***51-75%*** ○ **OCCASIONAL** ***26-50%*** ○ **INTERMITTENT** ***0-25%***

DOES PAIN SPREAD TO OTHER AREAS? **IF SO, WHERE?** _____

DO YOU HAVE ANY NUMBNESS OR TINGLING IN YOUR BODY? WHERE?_____

DOES ANYTHING AGGRAVATE THE COMPLAINT? _____

DOES ANYTHING MAKE THE COMPLAINT BETTER? _____

SPECIFIC INJURY? ○ **YES** ○ **NO**		**PRIOR TREATMENT?** ○ **YES** ○ **NO**	
HAD TREATMENT? ○ **YES** ○ **NO**		**TX TYPE:** ○ Drugs ○ Nv Block ○ Phys Therapy ○ Surgery ○ Xray ○ MRI ○ EMG	

MEDICAL HISTORY	**YES**	**NO**	***LIST MEDICATIONS / VITAMINS / SUPPLEMENTS***	
ARTHRITIS	○	○	**1.**	**4.**
CANCER	○	○	**2.**	**5.**
DIABETES	○	○	**3.**	**6.**
HEART PROBLEMS	○	○	***LIST ALLERGIES***	
HIGH BLOOD PRESSURE	○	○	**1.**	**3.**
VASCULAR PROBLEMS	○	○	**2.**	**4.**
LUNG PROBLEMS	○	○	**5.**	**6.**
STOMACH PROBLEMS	○	○	***LIST SURGERIES/HOSPITALIZATIONS***	
USUAL CHILDHOOD DISEASES	○	○	**1.**	
EXERCISE REGULARLY	○	○	**2.**	
SMOKER	○	○	**3.**	
ALCOHOL	○	○	**4.**	
ALLERGIES/ASTHMA	○	○		

HEIGHT:	**WEIGHT:**	***QUESTIONS/CONCERNS:***

FAMILY HEALTH HISTORY

HEALTH PROBLEMS OF RELATIVES	**RELATIVE:**	**HEALTH PROBLEM:**	
	RELATIVE:	**HEALTH PROBLEM:**	
DEATHS IN IMMEDIATE FAMILY	**RELATIVE:**	**CAUSE:**	**AGE AT DEATH:**
	RELATIVE:	**CAUSE:**	**AGE AT DEATH:**

SOCIAL AND OCCUPATIONA HISTORY:

JOB DESCRIPTION:	**WORK SCHEDULE:**
RECREATIONAL ACTIVITIES / LIFESTYLE (hobbies, level of exercise, alcohol, tobacco and drug use, diet) :	

The Drugless Doctors
Anthony DeMaria DC | Casen DeMaria DC | Robert DeMaria DC DABCO
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Practice Member Name: _____ **Date: _____**

Terms of Acceptance

Informed Consent:

A practice member, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the practice member in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the practice member susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the practice member to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a practice member by a physician at The Drugless Doctors, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Circle one **Women Only:** *Circle one*

To the best of my knowledge **(I am / am NOT)** pregnant and **(give permission / don't give permission**) to x-ray me for diagnostic interpretation.
Pregnancy Complications: _____

Missed Appointments:

There is a possible cancellation fee charged for appointments that are not canceled in advance. Visits missed while on a care plan must be made up within the time frame of the care plan.

Guarantee of Results:

The purpose of chiropractic care is to improve the health and function of the spine and nervous system. It is not to treat disease, suppress symptoms, medically diagnose, perform surgery or prescribe medications. If you desire any of these we will gladly refer you for those services. Practice member acknowledges that any and all questions regarding benefits, risks and alternatives have been answered to their satisfaction.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____Children: _____Others:_____ No one: ___

Please indicate if our office can leave a message on your voicemail regarding your personal health information. Y [ ] N [ ]

Please indicate if we can text office updates in the case of weather alerts or special office announcements. Y [ ] N [ ]

Please indicate if we can send email information to the provided email address through unsecure means. Y [ ] N [ ]

Preferred Communication Voicemail Y/N Text Y/N Email Y/N

Release of Medical Information:

I certify that I (or my dependent) assign directly to The Drugless Doctors all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize this office to release any information requested by my insurance company to document my claim for benefits. I understand that I am personally responsible for full payment of all charges for my treatment. Services are payable at the time rendered. X-rays remain the property of this clinic and will only be released to another physician after receiving a proper release authorization request from said physician. X-ray will not be released directly to practice members.

Determination of Treatment:

I understand and agree that the doctors of The Drugless Doctors have the right to decline or accept me as a practice member at any time before treatment begins. Taking a history and conducting an examination are a part of the process of information gathering, so that the doctor can determine whether to admit me as a practice member or not.

Minor Consent:

I am authorized to and do consent to all treatments performed by the doctors and staff of The Drugless Doctors and rendered to the minor practice member named on this registration form.

Acknowledgement:

I have read and fully understand the above statements. I have received and/or reviewed the notice of privacy practices **(*HIPAA-Posted at druglessdrs.com/new-member-info*)** and understand that I have the opportunity to discuss my right to privacy upon request.

Print Name: _____ Signature: _____ Date: _____