PATIENT REGISTRATION:

Please print and complete all areas

Date _____ How did you know about our office? _____
Where did you find our phone number? _____
Primary Care Physician _____

If a friend or family member referred you, may we send them a thank you? YES NO

Patient Name :_____ Age _____

Address _____Apt # _____

City _____State _____Zip_____

SS # _____ Male/Female Married/ Single/ Divorced/ Widowed

Student? Y N Date of birth_____

1-Home #_____

2-Work # _____

3- Mobile # _____ Cell provider (for text confirmation)_____
BEST contact # Home Work Mobile

Email: _____ for reminders and office / holiday hours

Accident related to employment (on-the-job)? Yes No Motor vehicle accident? Yes No

Emergency? Yes No Date complaints began _____

Name of spouse _____ Contact phone # for emergency _____

Name of other nearest relative or friend _____ phone _____

****

FINANCIAL RESPONSIBILITY*: You are responsible for any charges/money due for services supplied by this office as part of any/all management of your treatment and healthcare. ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE WITH THE OFFICE.

**THERE WILL BE A $30 nsf FEE FOR ANY RETURNED CHECKS **

** YOU WILL BE RESPONSIBLE FOR ANY AND ALL LEGAL FEES OCCURRED WHILE ATTEMPTING TO COLLECT OUTSTANDING BALANCES **

I understand and agree to the previous disclaimer:

Signature _____

NAME _____ **FILE #** _____ **DATE** _____

Please describe your current complaint(s) – be very specific and include all areas:

1._____

2._____

3._____

Current problem / illness began: Gradual Suddenly **Cause**: _____ /unknown

Have you had this complaint before? Yes No when? _____

Have you seen another doctor for this complaint? YES NO

If yes, who? _____ **Treatment?** _____

Have you ever had chiropractic care? YES NO **How long ago?** _____

Home/medical treatment? (ex: heat, ice, ibuprofen)_____

Occupation _____

Daily activities: Sit stand computer work telephone driving manual labor travel reading

Vision:glasses /contacts /corrective surgery

Nausea? Y N // **Dizziness**? Y N // **Any changes in hearing, taste, vision, smell**? Y N

Trouble swallowing? Y N // **Bite tongue or cheek**? Y N // **Numbness or tingling**? Y N

NECK PAIN: describe area / side _____

How often:Constant…frequent …occasional…rarely **Pain**: (none)0 1 2 3 4 5 6 7 8 9 10(worst)

Sensation: Dull-sharp-burning- stabbing-ache-diffuse-shooting-stiff-numb-tingling-_____

It **moves from** the neck **to** _____

What makes it **worse**? _____What makes it **better**? _____

Activities now limited? (ex: work, sleep, pleasure)_____

Symptoms: getting worse[ ] Staying the same[ ] Getting better [ ]

MID BACK PAIN: describe area / side _____

How often:Constant…frequent …occasional…rarely **Pain**: (none)0 1 2 3 4 5 6 7 8 9 10(worst)

Sensation: Dull-sharp-burning- stabbing-ache-diffuse-shooting-stiff-numb-tingling-_____

It **moves from** the mid back **to** _____

What makes it **worse**? _____What makes it **better**? _____

Activities now limited? (ex: work, sleep, pleasure)_____

Symptoms: getting worse[ ] Staying the same[ ] Getting better [ ]

LOW BACK PAIN: describe area / side _____

How often:Constant…frequent …occasional…rarely **Pain**: (none)0 1 2 3 4 5 6 7 8 9 10(worst)

Sensation: Dull-sharp-burning- stabbing-ache-diffuse-shooting-stiff-numb-tingling-_____

It **moves from** the low back **to** _____

What makes it **worse**? _____What makes it **better**? _____

Activities now limited? (ex: work, sleep, pleasure)_____

Symptoms: getting worse[ ] Staying the same[ ] Getting better [ ]

OTHER AREA(S): _____ describe area / side _____

How often:Constant…frequent …occasional…rarely **Pain**: (none)0 1 2 3 4 5 6 7 8 9 10(worst)

Sensation: Dull-sharp-burning- stabbing-ache-diffuse-shooting-stiff-numb-tingling-_____

It **moves from** the _____ **to** _____

What makes it **worse**? _____What makes it **better**? _____

Activities now limited? (ex: work, sleep, pleasure)_____

Symptoms: getting worse[ ] Staying the same[ ] Getting better [ ]

Is there any other information you need to share? _____

Crossroads Natural Health 3125 S. Carrier Pkwy. Grand Prairie, TX 75052

Patient Name: _____ File _____ Date_____

Please place an "X" next to ALL present symptoms :

HEAD
[ ] Headache
  [ ] Sinus (Allergy)
  [ ] Migraine
  [ ] Back Of Head
  [ ] Forehead
  [ ] Temples
  [ ] Entire Head
[ ] Loss of Memory
[ ] Head Feels Heavy
[ ] Light Headedness
[ ] Dizziness
[ ] Fainting
[ ] Loss Balance
[ ] Blurred Vision
[ ] Double Vision
[ ] Light Bothers Eyes
[ ] Buzzing in Ears
[ ] Ringing in Ears
[ ] Pain in Ears

NECK
[ ] Pain in Neck
[ ] Neck Pain w/Movement
[ ] Pinched Nerve
[ ] Neck Feels Out of Place
[ ] Muscle Spasms in Neck
[ ] Grinding Sounds in Neck
[ ] Popping Sounds in Neck
[ ] Arthritis in Neck

MID-BACK
[ ] Mid-Back Pain
[ ] Pain Between Shoulder Blades
[ ] Pain From Front to Back

GENERAL
[ ] Nervousness
[ ] Irritable
[ ] Depressed
[ ] Feel Run-Down
[ ] Norm. Sleep_____Hrs. Per Night
[ ] Poor Sleep _____Hrs. Per Night
[ ] Weight Gain/Loss_____lbs.
[ ] Coffee_____Cups Per Day
[ ] Tea_____Cups Per Day
[ ] Cig._____Pks. Per Day
[ ] E-Cig._____Uses Per Day
[ ] Alcohol_____Drinks Per Day
[ ] Diabetes
[ ] Hypoglycemia (low blood Sugar)
[ ] Exercise___min/day___days/week
[ ] Other_____

SHOULDERS
[ ] Pain in Shoulder Joint (R-L)
[ ] Pain Across Shoulder
[ ] Bursitis (R-L)
[ ] Can't Raise Arm (R-L)
  [ ] Above Shoulder
  [ ] Over Head
[ ] Tension in Shoulders
[ ] Muscle Spasms (R-L)

ARMS & HANDS
[ ] Pain in Upper Arm (R-L)
[ ] Pain in Elbow (R-L)
[ ] Pain in Forearm (R-L)
[ ] Pain in Hands (R-L)
[ ] Pain in Fingers (R-L)
[ ] Tennis Elbow (R L)
[ ] Numbness in Arm (R-L)
[ ] Cold Hands (R-L)
[ ] Loss of Grip Strength (R-L)
[ ] Arthritis
[ ] Swollen Joints in Fingers (R-L)
[ ] Sore Joints in Fingers (R-L)
[ ] Arthritis in Fingers (R-L)
[ ] Numbness in Fingers (R-L)
[ ] Pins & Needles Sensation–Fingers (R L)
[ ] Fingers "Fall Asleep' (R-L)

HIPS, LEGS & FEET
[ ] Pain in Hip Joint (R-L)
[ ] Pain Down Leg (R-L- Both)
[ ] Knee Pain
  [ ] Inside
  [ ] Outside
[ ] Leg Cramps (R-L)
[ ] Feet Cramps (R-L)
[ ] Pins & Needles Sensation in Legs (R-L)
[ ] Numbness of Leg, Feet, Toes
[ ] Swollen Ankles (R-L)
[ ] Swollen Feet (R-L)
[ ] Feet Feel Cold

ABDOMEN
[ ] Nervous Stomach
[ ] Food Unable to Eat_____
[ ] Nausea
[ ] Gas
[ ] Constipation
[ ] Diarrhea
[ ] Hemorrhoids

LOW-BACK
[ ] Low Back Pain
[ ] Lower Lumbar
[ ] Sacroiliac
[ ] Low Back Pain is worse when:_____
[ ] Pain Relieved when:_____
[ ] Slipped Disk
[ ] Low-Back feels out of place
[ ] Muscle Spasms
[ ] Arthritis
[ ] Movement Aggravated

WOMEN ONLY
[ ] Last Menstrual Period_____
[ ] Pregnant
[ ] Menstrual Pain_____(Location)
[ ] Cramping
[ ] Irregularity
[ ] Cycle_____Days
[ ] Birth Control_____**(Type)**
[ ] Hysterectomy: (Partial- Full)
[ ] Genital Cancer
[ ] Discharge: Color_____
[ ] Tumors or Cysts
[ ] Abortions
[ ] Menopause

MEN ONLY
[ ] Urinary Frequency: (Increase Decresase)
[ ] Difficulty in Starting
[ ] Night Urination
[ ] Prostate Pain/Swelling

Remarks:_____

Please list known family history of illness/conditions: (ie. Heart, stroke, cancer, diabetes, etc.)

_____

SIGNIFICANT illness/injuries/surgeries/broken bones:_____

_____

CONSENT FOR TREATMENT

The nature of the Chiropractic adjustment. The primary treatment used at Crossroads Chiropractic is the spinal adjustment. We will use that procedure to treat you. We will use our hands or a mechanical device upon your body in such a way as to move your joints. That may cause you to hear a "pop" or "click" much as you might have experienced when you "crack" your knuckles. You may feel or sense movement.

The material risks inherent in Chiropractic adjustment.
As with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The probability of those risks occurring.
Any type of complication is very rare and generally results from some underlying weakness of the bone, which we check for during the taking of your history and during the examination and x-ray. Since even that risk should be avoided if possible, we employ tests in our examination, which are designed to identify if you may be susceptible to that kind of injury.
By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to Crossroads Chiropractic to perform the treatment and acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given to me.

[ ] I authorize Dr. Elizabeth Taylor to administer treatment as deemed necessary to treat my problem / condition.

Signed _____ **Date:** _____

Witness: _____ **Dr. Taylor** _____

***FEMALES ONLY*: To the best of my knowledge, I am NOT pregnant**

Signed:_____

Crossroads Natural Health, LLC
Dr. Elizabeth Taylor, Chiropractor
3125 –B S. Carrier Pkwy. 75052
P.O. Box 540369 75054-0369
972.641.7111 Grand Prairie, TX 972.660.1119 fax

PRIVACY NOTICE AGREEMENT

Patient consent for use and/or disclosure of protected health information to carry out treatment, payment and healthcare operations.

With my signature below, I give consent for Crossroads Chiropractic, Wellness and Pain Management (the Practice) to use and/or disclose information about me (or for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and healthcare operations.

I have reviewed the Privacy Policy of this Practice prior to signing this consent. The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy by request.

I have the right to request restrictions on how my information is used and/or disclosed in order to execute treatment, payment, or healthcare operations. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re-disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

The Practice may communicate confidential information to me including any invoices for services, reminder cards, birthday cards, newsletters, and the like, at the address/phone number/fax number/email address designated in my registration forms.

_____ ____/____/_____
Patient / Representative Date

Crossroads Natural Health
3125 South Carrier Parkway
Grand Prairie, TX 75052

972-641-7111

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Crossroads Natural Health & Dr. Elizabeth Taylor or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

Crossroads Natural Health & Dr. Elizabeth Taylor
3125 South Carrier Parkway
Grand Prairie, TX 75052

972-641-7111

Patient Authorization

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

_____

_____

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

_____
Name of Person Organization

_____
Name of Person Organization

Expiration Date of Authorization

This authorization is effective through _____ unless revoked or terminated by the patient or patient's personal representative.

Patient Rights

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

If you understand and agree with all of the above policies, please sign your name below.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date

Medication List

Patient Name_____ **Date**_____
File # _____

I do not take any prescription or "over the counter" medication [ ] Initials _____

- **Medication** _____

  Condition being treated _____

  Strength_____ How Many_____ How Often_____

- **Medication** _____

  Condition being treated _____

  Strength_____ How Many_____ How Often_____

- **Medication** _____

  Condition being treated _____

  Strength_____ How Many_____ How Often_____

- **Medication** _____

  Condition being treated _____

  Strength_____ How Many_____ How Often_____

- **Medication** _____

  Condition being treated _____

  Strength_____ How Many_____ How Often_____

Over The Counter list: _____

_____

_____

- **Allergies**_____

  _____

  _____