The Office of Charles F. Crandall, D.C. PA
1501 Lakeview Road Clearwater, FL 33756
(727) 447-6779 Fax (727) 462-2634

Chiropractic Registration

PATIENT INFORMATION

Date _____

Patient_____

Address_____

_____

Sex **M F** Birthdate_____ Age_____

Marital Status **Single Married Widowed Separated Divorced**

Occupation _____

Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home _____ Cell_____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship _____

Home Phone _____ Cell Phone _____

PATIENT CONDITION

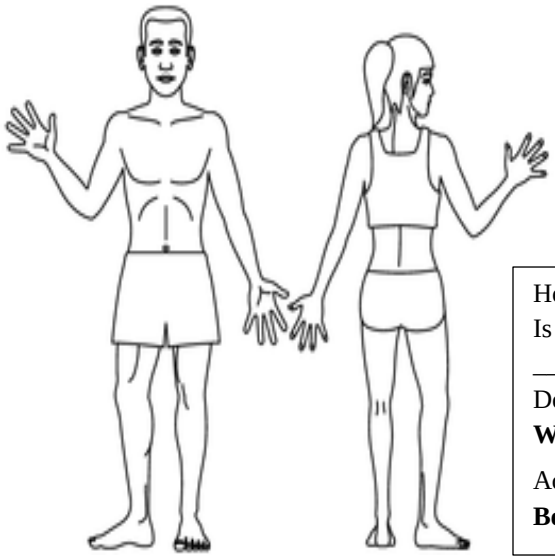
Reason for Visit _____

_____

When did you Symptoms appear _____

Is this condition getting worse? **Yes No Unknown**

Mark an **x** on the picture where you continue to have pain, numbness, tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (worst pain). _____

Type of pain: **Aching Dull Sharp Stabbing Throbbing Electric Fiery Shooting Deep**
Other _____

How often do you have this pain? _____
Is it constant or does it come and go? _____

_____

Does it interfere with your:
Work Sleep Daily Routine Recreation

Activities or Movements that are painful to perform:
Bending Sitting Standing Walking Rising from sitting

I, The undersigned understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Patient Health Questionnaire -

Charles F. Crandall D.C. PA
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Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] Weight [ ][ ][ ] lbs.
Feet *Inches*

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
						○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Ulcer	○	○	Pregnancy
○	○	Arthritis	○	○	Hepatitis	○	○	
○	○	Rheumatoid Arthritis	○	○	Liver/Gall Bladder Disorder			
						Other Health Problems/Issues		
○	○	General Fatigue	○	○	Cancer	○	○	
○	○	Muscular Incoordination	○	○	Tumor	○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____

CONSENT TO CHIROPRACTIC EXAMINATION, TREATMENT, AND OFFICE POLICIES ACKNOWLEDGEMENT

I hereby authorize Charles F Crandall, D.C. PA, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I also wish to rely on Dr. Crandall to make those decisions about my care, based on the facts then known, that they believe are in my best interest. The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction. Based on current findings, Dr. Crandall has discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. To aid the understanding of my condition and the reasons for the proposed course of care, the doctor has answered my questions regarding the planned treatments and course of care that I will receive. The doctor has also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time. I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor. I understand and accept that:

1. The cost of my proposed care has been provided to me. I understand that the clinic may submit appropriate charges my insurance company for reimbursement, but I am ultimately responsible for costs associated with my care.

2. I have the right to withdraw from or discontinue treatment at any time.

3. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.

4. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.

5. The Practice does not guarantee as to results with respect any course of care or treatment. I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive.

Our clinic strives to provide on time treatment with a strict policy of no overbooking. If a patient is late, we will do our best to accommodate around other scheduled appointments. We require 8 hours advance notice of appointment cancellation, so we can accommodate others wanting appointments.

Failure to provide this timely notice or no-show will result in a $30 charge to the patient's account.

My signature below acknowledges my consent to the examination, evaluation and treatments by the Practice; I have also reviewed the Privacy of Practices Notice and missed appointment policy.

_____ _____ _____

Patient's Printed Name Patient's Signature Date

Charles F. Crandall D.C. PA