REGISTRATION FORM

Date: _____

PATIENT INFORMATION:

Name as per IC (full): _____ Preferred name:_____

IC number: _____ Date of birth: _____ Age:_____ Gender: M / F

Address: _____

Home no.: _____ Mobile no.: _____ Email: _____

Occupation: _____ Preferred language: _____

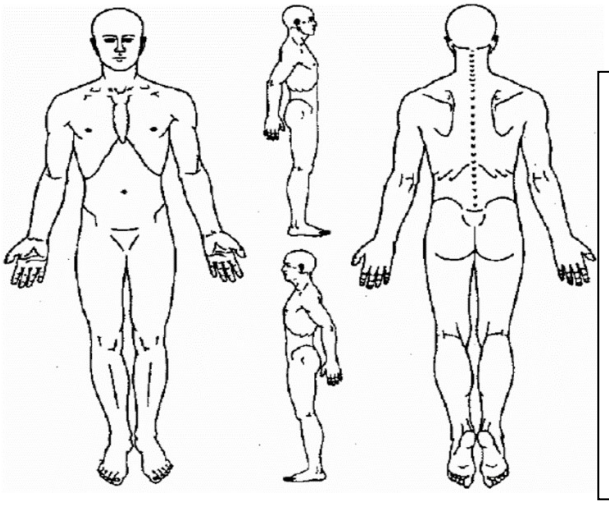
Emergency contact: Name: _____ Contact no: _____

Have you had chiropractic care before? Yes / No

How did you know us? (Please circle): Walk-in / Website / Facebook/ Referral (Name): _____

MAIN COMPLAINT: _____

Please circle where your complaint is in the diagram below:



Social History: (Please circle)

Marital Status: Single / Married

Number of Child: _____

Urinary and Bowel Habits: (Please circle)

Regular / Irregular / Controllable / Uncontrollable

HEALTH HABITS: (Please circle)

Exercise: Never / Occasional / Weekly / Daily

Smoke: Yes / No

Sleeping Pattern: Good / Moderate / Poor / Waken by pain, for _____ hours.

Stimulant Use: Alcohol _____ per day / Coffee _____ per day / Drugs, specify:_____

FAMILY AND PERSONAL HEALTH HISTORY: (Please circle the following if applicable)

Family: (Please specify relation: _____)

Diabetes / Heart disease / High blood pressure / Stroke / Cancer / Asthma

Tuberculosis / Hepatitis / HIV

Others: _____

Personal: _____

CONSENT FORM

Date: _____

CONSENT TO CHIROPRACTIC CARE.

I hereby assure that medical information I provided on the registration form is accurate. I understand that provision of inaccurate information could be dangerous to my health and it is my responsibility to update any changes to my medical information here in Specific Chiropractic.

I acknowledge that chiropractic care is an effective and non-invasive mode of care for many conditions. Nevertheless, I also recognize that, just like other health care procedures, there are risks associated with chiropractic procedure including assessment and treatment.

I understand that the rare risks associated with my proposed chiropractic care include and are not limited to muscle and joint soreness or strains, nausea, dizziness, fractures, disc injuries, and stroke.

In very rare circumstances some treatments of the neck may damage a blood vessel, this has known to lead to stroke or related symptoms (current statistics eg between 1 in 2 million to 1 in 5.85 million – Haldeman, et al. Spine vol 24-8 1999). However, there is no scientific evidence that confirms the cause and effect relationship between chiropractic treatment and the occurrence of stroke.

I hereby acknowledge my consent to the performance of the proposed chiropractic care which may include assessment like physical examination, xray analysis etc. and treatment like spinal adjustments, soft tissue therapy etc. by my chiropractor or any other chiropractor working in the clinic.

OUR COMPANY POLICY:

Cancellation Policy: I acknowledge that a fee of follow-up visit will be charged for any cancellation of scheduled appointment made with less than 24 hours prior notice or no show to the scheduled appointment.

Late-arrival Policy: I acknowledge that a fee of follow-up visit will be charged for tardiness of 15 minutes or more for scheduled appointment, with the scheduled appointment being cancelled.

I am financially responsible for the treatment in this clinic, or the treatment of the above minor (aged below 18 years old) under my care and agree to pay the fees which had been explained to me.

I have read this consent form and have been offered the opportunity to discuss with my chiropractor the nature, purpose, and risk of chiropractic treatment in general, the treatment options and recommendations for my condition, and questions in regards to this particular consent form.

I expect the terms in this consent form to be applied to all my chiropractic visits here in Specific Chiropractic.

Patient's or Legal Guradian's Signature: _____

Name as per IC (full): _____

IC number: _____