Kyu Yong John Lee, D.C. • Lee Chiropractic Wellness Center
PATIENT REGISTRATION FORM

PATIENT'S NAME (LAST, FIRST, MIDDLE)	HOME PHONE NO.	CELL #

STREET ADDRESS	CITY	STATE	ZIP

SEX: M ☐ F ☐	DATE OF BIRTH	MARITAL STATUS M ☐ S ☐ D ☐	SOCIAL SECURITY NO.	EMAIL ADD

OCCUPATION	EMPLOYER & ADD	WORK PHONE NO. OK TO CALL? Y ☐ N ☐

IN CASE OF EMERGENCY, CONTACT AND/OR NEAREST RELATIVE NOT LIVING WITH YOU: NAME & PHONE NO.	WHO REFERRED YOU TO US?

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY PHONE NO.	
ADDRESS OF INSURANCE COMPANY (STREET – CITY – STATE – ZIP)	
NAME OF INSURED	
WORK PHONE NO. OF INSURED	RELATIONSHIP TO INSURED
ID NUMBER	GROUP NUMBER

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY PHONE NO.	
ADDRESS OF INSURANCE COMPANY (STREET – CITY – STATE – ZIP)	
NAME OF INSURED	
WORK PHONE NO. OF INSURED	RELATIONSHIP TO INSURED
ID NUMBER	GROUP NUMBER

Please read and sign below. **FINANCIAL POLICY**

I understand that I am required to pay for all charges on the date services are rendered. Unless, I am covered by a PPO, EPO or government sponsored health plan in which the physician is a participating provider, and I am being seen for a service I know to be covered by my policy.

I understand that Kyu Yong John Lee, D.C. accepts MasterCard/Visa, my personal check, money order or cash. If the bank returns my check unpayable, I will be charged a $35.00 service fee, which will be due and payable within three days along with the amount of the original check.

I will pay all co-pays and deductibles on the date of service. I understand that if I receive a statement in the mail, the amount stating my responsibility is due in 10 days. If my account exceeds 90 days, I understand that I am in a collection status.

I understand that I am ultimately responsible for my account in full, even though I have medical insurance. Should there be a problem with my insurance company not paying in a timely manner or for the correct amount, I agree to pay the doctor and settle my differences with my insurance company within 90 days from the date of services. Also, I understand that I am responsible for any denied charges.

I hereby authorize payment directly to the Kyu Yong John Lee, D.C. or Lee Chiropractic Wellness Center of the insurance benefits otherwise payable to me. I understand I am financially responsible for charges not covered by this authorization. I also authorize that a photographic copy of this authorization is as valid as the original. I hereby authorize the disclosure of medical information to my stated insurance company for the purpose of obtaining payment for services rendered.

I understand and hereby authorize any or all of my medical and personal information to be forwarded to the billing and collection company and clearinghouse for the purpose of obtaining payment for services rendered.

1. **Other than yourself, with whom may we discuss your medical condition, treatment, and medical bills?**

Name:_____ **Relationship:**_____

Address: _____**Home #:**_____ **Work or Cell #:**_____

2. **May we leave confidential messages on your telephone answering machine or voice mail at home or work? Yes No**

I have read, agree and understand this financial policy.

_____

Signature of Patient **Please Print Your Name** Date

Informed Consent for Chiropractic Care

Lee Chiropractic Wellness Center - Kyu Yong John Lee, D.C.

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____

Print Name Signature Date

HEALTH QUESTIONNAIRES

Name **DOB** **Date**

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful deification
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow
☐ Reg. ☐ Irreg. ☐ Pain / cramps

Days of flow: _____

Length of cycle: _____

Date - 1st day last period: _____

Are you pregnant? ☐ yes, ☐ no

If yes, how many months? _____

How many children do you have?_____

Birth control method: _____

Date of last PAP test: _____
☐ normal, ☐ abnormal

Date of last mammogram: _____
☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why:

_____

_____

_____

_____

Name **DOB** **Date**

Give a brief detailed description of the problem you are currently experiencing:

How long have you had this condition? _____ Is it getting worse? ☐ yes ☐ no _____

Does it bother you (check appropriate box): ☐ work ☐ sleep ☐ other: _____

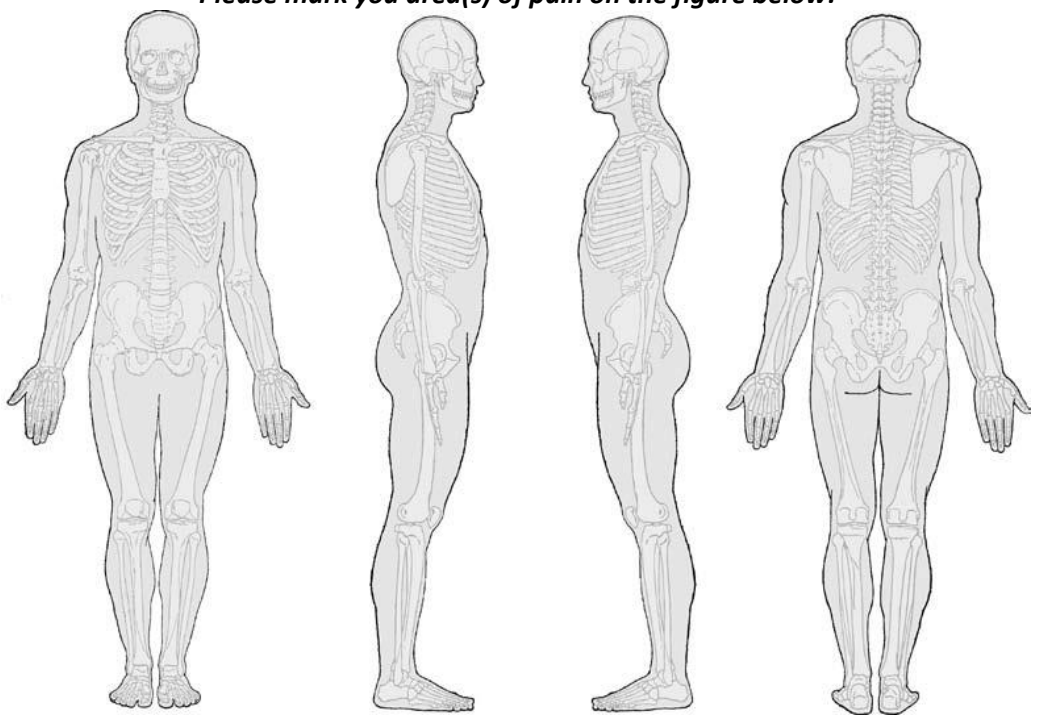
What seemed to be the initial cause: _____

Please place a mark at the level of your pain on the scale below:

Worst Possible Pain

No Pain

Please mark you area(s) of pain on the figure below:



Past Health History

Have you…	Yes	No	If yes, explain briefly
… been hospitalized in the last 5 year?	☐	☐	_____
… had any mental disorders?	☐	☐	_____
… had any broken bones?	☐	☐	_____
… had any strains or sprains?	☐	☐	_____
… ever used orthotics?	☐	☐	_____
Do you take minerals, herbs or vitamins?	☐	☐	_____

How is most of your day spent? ☐ standing, ☐ sitting, ☐ other: _____

How old is your mattress? _____

When was your last physical exam? _____

Habits	None	light	mod.	heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐
Salty foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐

Family history ***If any blood relative has had any of the following conditions, please check and indicate which relative(s)***

☐ Alcoholism	_____	☐ Cancer	_____	☐ High blood pressure	_____
☐ Anemia	_____	☐ Diabetes	_____	☐ High cholesterol	_____
☐ Arteriosclerosis	_____	☐ Emphysema	_____	☐ Multiple sclerosis	_____
☐ Arthritis	_____	☐ Epilepsy	_____	☐ Osteoporosis	_____
☐ Asthma	_____	☐ Glaucoma	_____	☐ Stroke	_____
☐ Bleed easily	_____	☐ Heart disease	_____	☐ Thyroid disease	_____

Do you have any other health issues or concerns that our staff should be made aware of?