REGISTRATION

Date ___________________________________

Name ____ **Age** _____________________________

Address ______________________ **City**______________________ **State**_____________ **Zip**___________

1 Mobile#______________________ **2 Home#**_______________________**3 Work#**_____________________

E-Mail ____

Best Contact # 1 2 3

Date of Birth___________________ Primary Care Physician_______________________________________

Male / Female Married / Single / Divorced / Widowed Student Yes / No

Employer ______________________ Phone ____________________ Contact Person __________________

Emergency Contact _____________________________ Phone #_____________________________________

Date complaint began ___________________________________ similar symptoms before? Yes / No

If Yes, When

____

____

____

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 health care.

I understand that I am fully responsible for my account. Upon default I am also responsible for any all reasonable collections and/or attorney fees, including a non-show or inadequate cancellation fee of 25.00 in any/both cases.

Signature:

____

Name: ____Date: ____________________

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

____

____

____

____

Have you seen another doctor/therapist for this complaint? Yes No If yes, Who__________________
____Treatment?____________________

____

List all previous surgeries of any type?

____

List all previous medical conditions treated by a doctor, including any current illness/conditions:
The current problem began: Gradual Suddenly
The cause of the current problem:

____

NECK PAIN: Describe area / side:
____ Constant Frequent

Occasional Mild Moderate Severe Extreme Dull Sharp Burning Stabbing Ache
Other: ____

MID BACK PAIN: Describe area / side:
____ Constant Frequent

Occasional Mild Moderate Severe Extreme Dull Sharp Burning Stabbing Ache
Other: ____

LOWER BACK PAIN: Describe area / side:
____ Constant Frequent

Occasional Mild Moderate Severe Extreme Dull Sharp Burning Stabbing Ache
Other: ____

OTHER AREAS: Describe area / side:
____ Constant Frequent
Occasional Mild Moderate Severe Extreme Dull Sharp Burning Stabbing Ache
Other: ____

The pain is worse: Morning Evening Daily Activities Increased Activities
The pain interferes with: Work Sleep Daily Activities Other: ______________________

Pregnant: Yes No Headaches? Yes No If Yes, describe how often: ____________________________

C. Steven Valenzuela

1244 William D. Tate Ave.
817-305-6548
TIN 56-2585232

PRIVACY NOTICE AGREEMENT

Patient consent for use and/or disclosure of protected health information to carry out treatment, payment and health care operations.
With my signature below, I give consent for Mr. C. Steven Valenzuela 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 health care operations.
I have the right to request restrictions on how my information is used/or disclosed in order to execute treatment, payment and health care operations. While Mr. Valenzuela is not required to agree to the restrictions, he 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 Mr. Valenzuela, but revocations 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. Any re-disclosure by said recipient may not be protected by federal privacy law.
Mr. Valenzuela may communicate confidential information to me including any invoices for services, reminders cards, birthday cards, newsletters, and the like, at the address/phone number/e-mail address designated in my registration forms.

I authorize Mr. C. Steven Valenzuela to administer treatment as deemed necessary to treat my problem/condition.

Patient/Client/Representative Date

AUTHORIZATION TO TREAT A MINOR CHILD

I hereby authorize C. Steven Valenzuela to administer Orthopedic Manual Therapy and adjunctive physiotherapy as deemed necessary to my child.

Name of child Printed

Signature of Parent or Legal Guardian Print

____

Witness Date

____