



**REGENT PARK CHIROPRACTIC, LLC**  
[www.RegentParkChiro.com](http://www.RegentParkChiro.com)

1046 Regent Parkway, Suite 106  
Fort Mill, SC 29715  
Phone - 803.396.1501  
Fax - 803.396.1503

Roy N. Van Dyke, DC

Date: / /

PATIENT INFORMATION
Name:
Address:
Patient Date of Birth:
Sex: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> widowed <input type="checkbox"/> divorced
Patient Social Security #:
Occupation:
Employer:
Employer phone:
Employer Address:
Who may we thank for referring you:

INSURANCE INFORMATION
Are you covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Insurance Company:
Subscriber Name:
Subscriber's Date of Birth:
Subscriber's Employer:
Relationship to patient: (check below)
<input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> parent/guardian <input type="checkbox"/> other
<b>Assignment &amp; Release:</b>
I certify that I have insurance coverage and assign directly to Regent Park Chiropractic, LLC all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. <b>Date:</b> / /
Signature:

**CONTACT INFORMATION**

Home Phone:
Work Phone:
Cell Phone:
Preferred contact: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
E-mail:

Emergency Contact:
Relationship:
Home Phone:
Work Phone:
Cell Phone:

Reason for visit:	
When did it start:	How did it start:
Is your condition due to an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes (if so what type) <input type="checkbox"/> Work-related <input type="checkbox"/> Vehicle <input type="checkbox"/> Other:	
Please describe your condition:	
Is your condition getting worse? <input type="checkbox"/> No <input type="checkbox"/> Yes	Is it constant or does it come and go? <input type="checkbox"/> Constant <input type="checkbox"/> Comes and goes <input type="checkbox"/> Don't know
Does it interfere with your: <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily activities <input type="checkbox"/> Sports/Recreation <input type="checkbox"/> Other:	
<b>Do you experience pain with:</b> <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Sitting <input type="checkbox"/> Bending <input type="checkbox"/> Lying down <input type="checkbox"/> Lifting <input type="checkbox"/> Sports <input type="checkbox"/> Self-Care	
<b>What treatments have you already had for this condition?</b> <input type="checkbox"/> Medical <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Surgical <input type="checkbox"/> X-Ray/MRI <input type="checkbox"/> Other: <input type="checkbox"/> None	
With whom?	



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**Health History – (Please read the list and check any items that apply to you)**

Previously Diagnosed or Current Conditions		
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anemia	<input type="checkbox"/> Herniated disc/degenerated disc	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> High blood cholesterol	<input type="checkbox"/> Tumors
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> High blood pressure	<b>Others: (Please list)</b>
<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple sclerosis	
<input type="checkbox"/> Chemical dependency	<input type="checkbox"/> Osteoporosis/Osteopenia	
<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Pinched nerve	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Polio	
<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Prostate problems	
<input type="checkbox"/> Headaches	<input type="checkbox"/> Rheumatoid arthritis	
<b>Height:</b> feet    inches	<b>Weight:</b> Pounds	
Please list any prior surgeries or significant injuries (include date)		

**Family History (Does anyone in your family have any of the following)**

<input type="checkbox"/> Autoimmune disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Seizure disorders

MEDICATIONS	ALLERGIES	VITAMINS/SUPPLEMENTS/HERBS

My work duties include: <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Light labor <input type="checkbox"/> Heavy labor <input type="checkbox"/> Other:
My exercise level is: <input type="checkbox"/> Intense <input type="checkbox"/> Moderate <input type="checkbox"/> Light <input type="checkbox"/> Minimal List Activities:
My habits include: <input type="checkbox"/> Smoking/Tobacco use _____ packs/day <input type="checkbox"/> Alcohol consumption _____ drinks/week <input type="checkbox"/> Caffeine (coffee, soda, tea) _____ cups/day <input type="checkbox"/> High stress level: _____

<b>Primary Care Provider:</b> <b>Name:</b> _____ <b>Date last seen:</b> _____
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<b>Patient Signature:</b> _____ <b>Date:</b> _____
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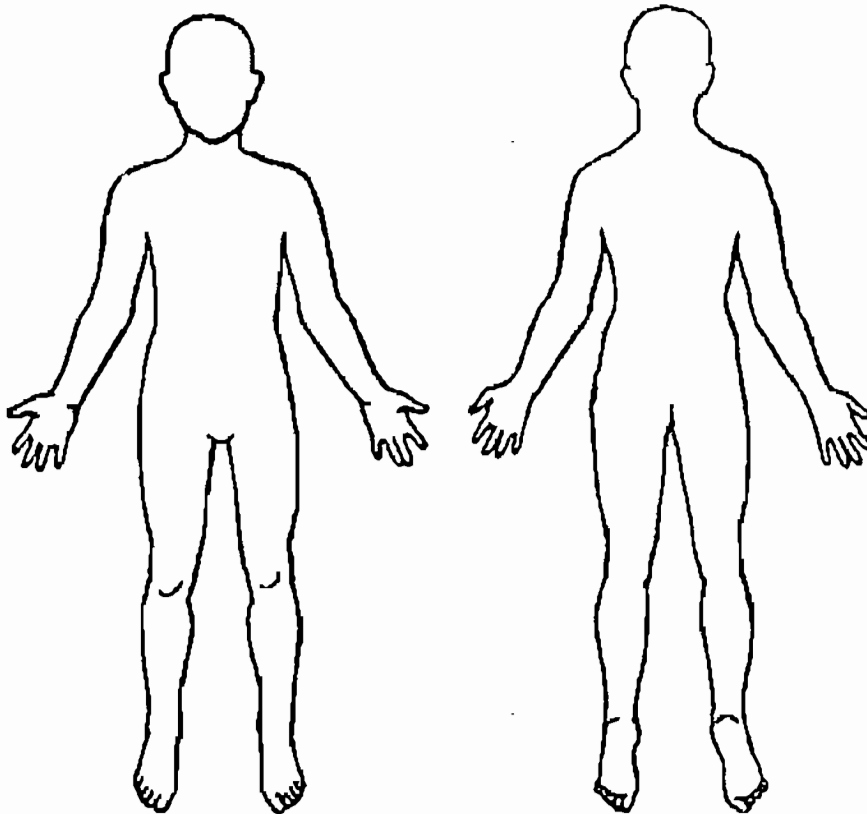
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Roy N. Van Dyke, DC

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Please Print)*

Please draw the location of your symptoms on the body diagram below and mark your current level of pain on the line at the bottom of the diagram.

**RIGHT                      LEFT                      LEFT                      RIGHT**



No Pain |-----| Worst Possible Pain  
Please make a slash through this line as to the level of your pain.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# REGENT PARK CHIROPRACTIC, LLC

## CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATIONS

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. **This information is kept private except for uses involved in your healthcare.** A copy of the summary of the HIPAA Privacy Rule is available for your review in this office.

**I understand that this information serves as:**

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and prior health information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

**I understand that:**

- I have the right to object to the use of my health information for directory purposes.
- I have access to a copy of the "Notice of Patient Privacy Rights" and they are available in the office.
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that the organization is not required to agree to the restrictions requested.
- I have the right to revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.
- I have the right to request a copy of my records. I understand this requires 48 hours notice.
- I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by recipient and that this information will no longer be subject to protected health information.

**I request the following additional restrictions to the use or disclosure of my health information:**

\_\_\_\_\_

**I authorize Regent Park Chiropractic, LLC to speak with the following people regarding my healthcare:**

\_\_\_\_\_

With my consent, Regent Park Chiropractic, LLC may call my home or other designated location, and leave a voice message in ~~reference to any items that~~ assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and information pertaining to my clinical care.

With my consent Regent Park Chiropractic, LLC may send a narrative to my primary care doctor explaining my evaluation and treatment plan.

**PATIENT:**

X \_\_\_\_\_

Signature of Patient/Legal Representative

\_\_\_\_\_

Date

# REGENT PARK CHIROPRACTIC, LLC

1046 REGENT PARKWAY, SUITE 106

FORT MILL, S.C. 29715-8393

PH: (803) 396-1501

FAX: (803) 396-1503

## *Informed Consent*

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes Chiropractic health care. We want you to be informed about potential problems associated with Chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the manipulation of bones. This may be preformed manually and/or mechanically. Frequently adjustments create a "popping" or "clicking" sound/sensation in the area being treated. In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy, exercise instruction, inter-segmental traction, etc.

**Soreness:** It is common for chiropractic adjustments to result in a temporary increase in soreness of the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. Although not dangerous, you should notify the doctor if you feel tenderness or soreness in the treated area.

The following are explanations of extremely rare but possible issues that potentially could result from chiropractic treatment. These problems occur so rarely, that in most cases, there are no available statistics to quantify their probability. Statistics have been provided where available.

**Disc Herniations:** Disc Herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractic physicians. This includes both the neck and back. Yet, occasionally chiropractic treatment will aggravate the problem and rarely surgery may also cause a disc problem if the disc is in a weakened condition.

**Soft Tissue Injury:** Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely chiropractic adjustments may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term effects for the patient.

**Rib Fractures:** The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone. This is referred to as a fracture. This occurs only in patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully and especially those where osteoporosis has been evidenced on their x-rays. Rarely, calcified rib cartilage, stiffened with age, separates slightly from the ribs near the sternum. This may require a rib belt to be worn for a few weeks to stabilize and protect this area while healing.

**Physical Therapy Burns:** Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be blistering of the skin.

**Stroke:** Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to vertebral artery stroke is called the “extension-rotation-thrust atlas adjustment”. We do not do this type of adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies, reported in Canada in July 2001, estimate that the incident of this type of stroke is 1 per every 5,680,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before he would statistically be associated with a single patient stroke.

**Other problems:** There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These occur so rarely that it is not possible to anticipate and/or explain all of them in advance of treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease or condition as a result of treatment in this clinic. We will always give you our best care and if the results are not acceptable we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding of the above please sign and date below.

\_\_\_\_\_  
Patient’s Name (Please Print)

\_\_\_\_\_  
Today’s Date

\_\_\_\_\_  
Patient’s Signature

\_\_\_\_\_  
Parent/Guardian Signature for Minor

**VBI (STROKE) RISK IN PERSPECTIVE**

RISK	BASIS [AND REFERENCE]
30%	Incidence of adverse drug event in hospitalized patients. (Anderson, 1992)
10%	Incidence of psychosis due to corticosteroid therapy. (Harvey, 1984)
7-10%	Incidence of hepatitis due to blood transfusion. (Stehling, 1984)
6.1%	Incidence of infection in postoperative orthopedic patients. (Fernandez et al., 1992)
3.76%	Incidence of nosocomial infection in hospitalized patients in the U.S.A. (Centers for Disease Control, 1991)
1-2%	Incidence of paralysis due to neurosurgery of the cervical spine. (Rocha vs. Harris, 1987)
0.7%	Incidence of esophageal perforation during anterior approach cervical spine surgery. (Van Berge Henegouwan et al., 1991)
0.3-0.9%	Incidence of death due to cervical spine surgery. (Graham, 1989)
0.057%	Incidence of seizure due to D.P.T. Vaccine. (C.D.C., 1994)
0.012%	Incidence of breast cancer due to mammography. (Bushong, 1984)
0.005-0.0015%	Incidence of death from radiation-induced malignancy due to x-ray exposure of 1-RAD. (Bushong, 1984)
0.0025-0.01%	Incidence of death due to radiocontrast media (Atkinson & Kaliner, 1992)
0.0008-0.001%	Incidence of death due to allergic reaction to anesthetic agents. (Anderson, 1992)
0.00002-0.00008% (2-8 per million)	Incidence of death due to lightning in the U.S.A. (Eriksson & Ormehult, 1998)
0.00001-0.00003% (1-3 million)	Incidence of serious neural complications due to cervical manipulation. (Cyriax, 1978. And Gutman, 1983 Respectively)
0.000568%	(1 per 5.68 million) Risk of Stroke associated with Neck Adjustment, (Haldeman & Carey, 2001)

{Note: The risk of stroke due to chiropractic cervical adjustment is so remote that informing patients is not required, according to California Superior Court judicial opinion. (Joams vs. Ross, 1993)}

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