CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____
City State Zip

Sex: ☐ M ☐ F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

3 PHONE NUMBERS

Home _____ Work _____ Ext ____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

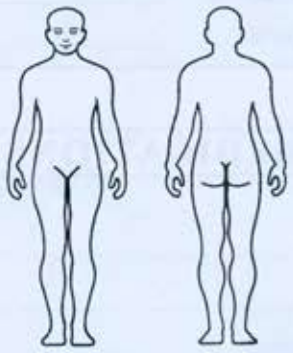
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



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

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ 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 ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

– OVER –

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other_____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____
Spinal Exam_____ Chest X-Ray_____ Urine Test_____
Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Alcoholism ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Allergy Shots ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Parkinson's Disease ☐ Yes ☐ No	Tumors, Growths ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Typhoid Fever ☐ Yes ☐ No
Bleeding Disorders ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Vaginal Infections ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Prosthesis ☐ Yes ☐ No	Whooping Cough ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Other _____
Cataracts ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No	Rheumatoid Arthritis ☐ Yes ☐ No	
Chemical Dependency ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No	
Chicken Pox ☐ Yes ☐ No	Measles ☐ Yes ☐ No		
Diabetes ☐ Yes ☐ No	Migraine Headaches ☐ Yes ☐ No		

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking Packs/Day_____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day_____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

Pharmacy Name_____
Pharmacy Phone _____

ALLERGIES

VITAMINS/HERBS/MINERALS