CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Date_____

Social Security #_____

Email _____

First Name_____

Last Name_____

Address _____

City_____

State_____ Zip_____

Sex M F Age_____

Birthdate_____

□ Married □ Widowed □ Single □ Minor

□ Separated □ Divorced □ Partnered for _____years

Patient Employer/School_____

Occupation_____

Employer/School Address_____

_____

Employer/School Phone (_____)_____

Spouse's Name _____

Birthdate_____

SS#_____

Whom may we thank for referring you?_____

PHONE NUMBERS

Cell Phone (_____)_____

Home Phone (_____)_____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Cell Phone (_____)_____

Work Phone (_____)_____

INSURANCE INFORMATION

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 certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Chiropractic and Health Center 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 my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

ACCIDENT INFORMATION

Is this 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 □ Workers Comp □ Other

Attorney Name (If applicable)_____

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)_____

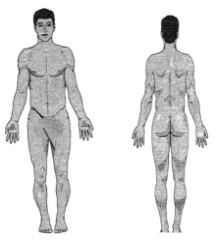
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Swelling Other

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



HEALTH HISTORY

What treatment have you already received for your condition? [ ] Medication [ ] 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	Diabetes	[ ] Yes [ ] No	Liver Disease	[ ] Yes [ ] No	Rheumatic Fever	[ ] Yes [ ] No
Alcoholism	[ ] Yes [ ] No	Emphysema	[ ] Yes [ ] No	Measles	[ ] Yes [ ] No	Scarlet Fever	[ ] Yes [ ] No
Allergy Shots	[ ] Yes [ ] No	Epilepsy	[ ] Yes [ ] No	Migraine Headaches	[ ] Yes [ ] No	Sexually Transmitted	
Anemia	[ ] Yes [ ] No	Fractures	[ ] Yes [ ] No	Miscarriage	[ ] Yes [ ] No	Disease	[ ] Yes [ ] No
Anorexia	[ ] Yes [ ] No	Glaucoma	[ ] Yes [ ] No	Mononucleosis	[ ] Yes [ ] No	Stroke	[ ] Yes [ ] No
Appendicitis	[ ] Yes [ ] No	Goiter	[ ] Yes [ ] No	Multiple Sclerosis	[ ] Yes [ ] No	Suicide Attempt	[ ] Yes [ ] No
Arthritis	[ ] Yes [ ] No	Gonorrhea	[ ] Yes [ ] No	Mumps	[ ] Yes [ ] No	Thyroid Problems	[ ] Yes [ ] No
Asthma	[ ] Yes [ ] No	Gout	[ ] Yes [ ] No	Osteoporosis	[ ] Yes [ ] No	Tonsillitis	[ ] Yes [ ] No
Bleeding Disorders	[ ] Yes [ ] No	Heart Disease	[ ] Yes [ ] No	Pacemaker	[ ] Yes [ ] No	Tuberculosis	[ ] Yes [ ] No
Breast Lump	[ ] Yes [ ] No	Hepatitis	[ ] Yes [ ] No	Parkinson's Disease	[ ] Yes [ ] No	Tumors, Growths	[ ] Yes [ ] No
Bronchitis	[ ] Yes [ ] No	Hernia	[ ] Yes [ ] No	Pinched Nerve	[ ] Yes [ ] No	Typhoid Fever	[ ] Yes [ ] No
Bulimia	[ ] Yes [ ] No	Herniated Disk	[ ] Yes [ ] No	Pneumonia	[ ] Yes [ ] No	Ulcers	[ ] Yes [ ] No
Cancer	[ ] Yes [ ] No	Herpes	[ ] Yes [ ] No	Polio	[ ] Yes [ ] No	Vaginal Infections	[ ] Yes [ ] No
Cataracts	[ ] Yes [ ] No	High Blood		Prostate Problem	[ ] Yes [ ] No	Whooping Cough	[ ] Yes [ ] No
Chemical		Pressure	[ ] Yes [ ] No	Prosthesis	[ ] Yes [ ] No	Other_____	
Dependency	[ ] Yes [ ] No	High		Psychiatric Care	[ ] Yes [ ] No	_____	
Chicken Pox	[ ] Yes [ ] No	Cholesterol	[ ] Yes [ ] No	Rheumatoid Arthritis	[ ] Yes [ ] No	_____	
		Kidney Disease	[ ] Yes [ ] No				

EXERCISE	WORK ACTIVITY	HABITS
[ ] None	[ ] Sitting	[ ] Smoking Packs/Day_____
[ ] Moderate	[ ] Standing	[ ] Alcohol Drinks/Week_____
[ ] Daily	[ ] Light Labor	[ ] Coffee/Caffeine Drinks Cups/Day_____
[ ] Heavy	[ ] Heavy Labor	[ ] High Stress Level Reason_____

Are you pregnant? [ ] Yes [ ] No Due Date_____

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

MEDICATION	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name		
Pharmacy Phone		

Patient Signature: _____Date:_____