Chiropractic Registration and History

Patient Information

Date___/___/___

Patient_____

Street Address_____

City_____

State, Zip_____

Sex: M F

Age:_____

DOB:_____

Single Married Widowed

Separated Divorced

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Information

Spouse's Name_____

DOB_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?

_____

Insurance

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Insurance ID # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name_____

DOB _____

Relationship to Patient _____

Insurance Co. _____

Group #_____

Insurance ID # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assigned 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

Phone Numbers

Home #_____Work #_____ Ext____

Best time and place to reach you_____

Emergency Contact

Name_____ Relationship_____

Home #_____ Work #_____

Accident Information

Is the condition due to an accident? Yes No

Type of accident:

Auto Work Home Other:_____

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp.

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 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 _____

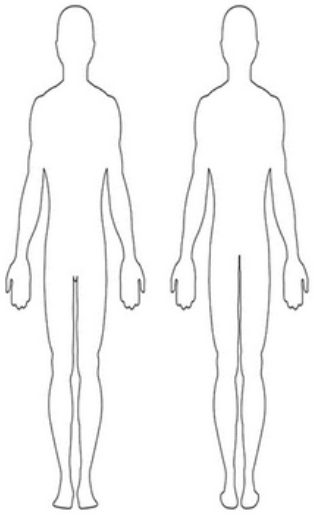
How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: Bending Lying Down Sitting

Work Sleep Daily Routine

Recreation Standing Walking



Health History

What treatment have you already recieved for your condition?

Medications Surgery Physical Therapy Chiropractic Services None Other_____

Name and address of 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 indiacate if you have had any of the following:

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

Exercise

__ None
__ Moderate
__ Daily
__ Heavy

Work Activity

__ Sitting
__ Standing
__ Light Labor
__ Heavy Labor

Habits

__ Smoking Packs/Day_____
__ Alcohol Drinks/Week_____
__ Caffeine Drinks/Day_____
__ High Stress Reason_____

Pregnancy

Are you pregnant?
__ Yes
__ No
Due Date_____

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

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERAL

Pharmacy Name_____

Pharmacy Number_____