CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

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 # _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for the 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
Name of Insurance Company(ies)
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 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 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 Signature of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (____)_____ Home Phone (____)_____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (____)_____ Work Phone (____)_____

4 FAMILY INFORMATION

Children's Name(s)	Sex	Date(s) of Birth
	M F	
	M F	
	M F	
	M F	

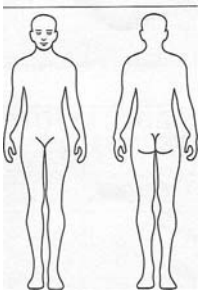
5 PATIENT CONDITION

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 this 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

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

EXERCISE

None
Moderate
Daily
Heavy

WORK ACTIVITIES

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

_____
_____
_____
_____
_____