CHIROPRACTIC REGISTRATION AND HISTORY

1) PATIENT INFORMATION

Date

Patient

Address

City State Zip

Sex M F Age Birth date

Single/Married/Widowed/Separated/Divorced

Driver's License #

Patient SS #

Occupation

Employer

Spouse's Name

Complete if Patient is a minor:

Guardian's SS #

Guardian's Dr. License #

Billing Address (if other than above)

Name

Address

Phone

2) INSURANCE

Who is responsible for this account?

Relationship to Patient

Insurance Co.

ID # Group #

Is patient covered by additional insurance? Yes No

Subscriber's Name

Birth date Relationship to Pt.

Insurance Co.

ID # Group #

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with and assign directly to Dr. Leone 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

Best time and place to reach you

How did you find out about our clinic?

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 Ins Employer Workers 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 have any symptoms.

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

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

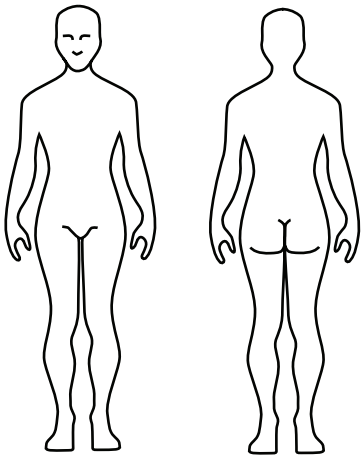
How often do you have this pain?

Is it constant or does it come and go?

Does it interfere with you Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform:

Sitting Standing Walking Bending Lying Down Twisting



6) HEALTH HISTORY

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

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

Date of last Physical Exam _____

Spinal Exam _____ Spinal X-Ray _____

What Serious Health Problems have you had?

_____

_____

_____

Exercise Yes ○ No ○ Type _____

Habits:
- Smoking
- Alcohol
- Coffee/Caffeine
- High Stress Level

Work Activity Sitting Standing Light Labor Heavy Labor

Packs/Day _____

Drinks/Day _____

Cups/Day _____

Reason _____

Are you Pregnant? Yes ○ No ○ Due Date _____

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

7) MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

I want to (circle all that apply): A. Just get rid of my pain B. Correct the cause of my pain C. Stay Healthy