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. 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

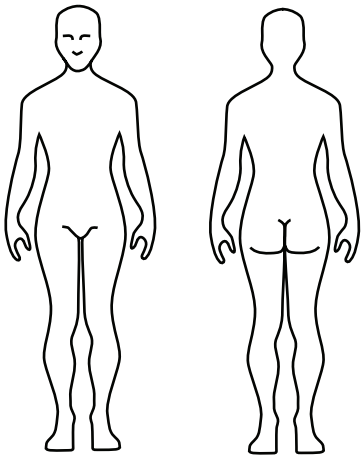
How often do you have this pain? _____

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 and address 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