# CHIROPRACTIC REGISTRATION & HISTORY

## PATIENT INFORMATION

ID# _____
(For office use only)

Date _____

Name _____
LAST NAME FIRST NAME INITIAL

Address _____

_____
City State Zip

Sex: ☐ M ☐ F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you?

_____

## INSURANCE

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, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign 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 _____

### IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work phone _____

## 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 Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

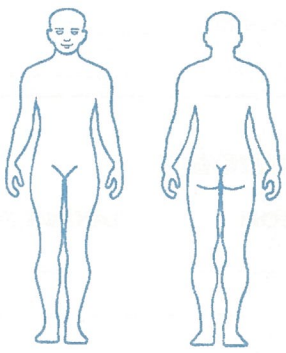
## PATIENT CONDITION

Reason for Visit _____

When did your symptoms begin? _____

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

– OVER –

## HEALTH HISTORY

Have you ever seen a Chiropractor before? ☐ Yes ☐ No

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 1st Treatment _____ Number of treatments in last 12 months _____

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 _____

**Please check ☑ symptoms you currently have:**

| | | | |
|---|---|---|---|
| ☐ Balance Impairment | ☐ Headaches | ☐ Loss of Memory | ☐ Vertigo |
| ☐ Burning Eyes | ☐ Lightheadedness | ☐ Nausea | ☐ Visual/Sensory Disturbance |
| ☐ Depression | ☐ Loss of Concentration | ☐ Ringing/Buzzing in Ears | |

**Please check ☑ conditions or symptoms you currently have or have had in the past:**

| | | | | |
|---|---|---|---|---|
| ☐ AIDS/HIV | ☐ Cataracts | ☐ Herniated Disk | ☐ Parkinson's Disease | ☐ Tuberculosis |
| ☐ Anemia | ☐ Chemical Dependency | ☐ Herpes | ☐ Pinched Nerve | ☐ Tumors, Growths |
| ☐ Anorexia | ☐ Diabetes | ☐ High Blood Pressure | ☐ Pneumonia | ☐ Ulcers |
| ☐ Appendicitis | ☐ Emphysema | ☐ High Cholesterol | ☐ Polio | ☐ Varicose Veins |
| ☐ Arthritis | ☐ Epilepsy | ☐ Jaw Pain/TMJ | ☐ Prosthesis | ☐ Whiplash |
| ☐ Asthma | ☐ Glaucoma | ☐ Kidney Disease | ☐ Psychiatric Care | Other _____ |
| ☐ Blood Clots | ☐ Goiter | ☐ Liver Disease | ☐ Rheumatoid Arthritis | _____ |
| ☐ Breast Lump | ☐ Gout | ☐ Mononucleosis | ☐ Rheumatic Fever | _____ |
| ☐ Bronchitis | ☐ Heart Disease | ☐ Multiple Sclerosis | ☐ Scarlet Fever | _____ |
| ☐ Bulimia | ☐ Hepatitis | ☐ Osteoporosis | ☐ Stroke | _____ |
| ☐ Cancer | ☐ Hernia | ☐ Pacemaker | ☐ Thyroid Problems | _____ |

### EXERCISE

☐ None ☐ Daily ☐ Moderate ☐ Heavy

### WORK ACTIVITY

☐ Sitting ☐ Light Labor ☐ Standing ☐ Heavy Labor

### LIFESTYLE

☐ Smoking Packs/Day_____ ☐ Coffee/Caffeine Cups/Day_____ ☐ Alcohol Drinks/Week____ ☐ High Stress Level Reason_____

Are you pregnant? ☐ Yes ☐ No Due Date_____

| Injuries/Surgeries you have had | Description | Date |
|---|---|---|
| Accidents/Falls | | |
| Head Injuries | | |
| Broken Bones | | |
| Dislocations | | |
| Surgeries | | |

## MEDICATIONS

| MEDICATION | TAKING FOR |
|---|---|
| | |
| | |
| | |
| | |

## ALLERGIES

## VITAMINS/SUPPLEMENTS