

CHIROPRACTIC REGISTRATION & HISTORY

PATIENT INFORMATION

Date _____

Name _____
LAST NAME FIRST NAME INITIAL

SS# _____

Address _____
CITY STATE ZIP

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Occupation _____

Employer _____

Employer Address _____
CITY STATE ZIP

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Company _____

ID# _____ GRP# _____

Insurance Phone # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Company _____

ID# _____ GRP# _____

Insurance Phone # _____

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. _____

Cell _____ E-mail Address _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Ext. _____

Cell 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 Other

Attorney Name (if applicable) _____

Address _____

Phone # _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms begin _____

Is this condition getting progressively worse? Yes No Unknown

Mark and X on the picture where you continue to have pain, numbness or tingling.

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

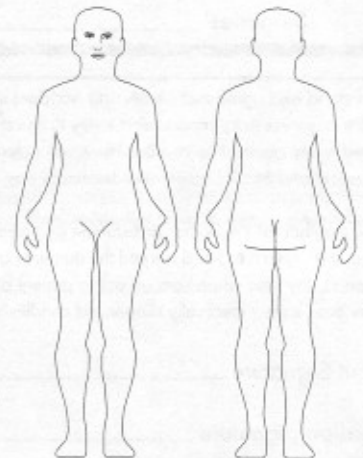
Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that re painful to perform Sitting Standing Walking



Bending

Lying Down

PATIENT INFORMATION

Have you ever seen a Chiropractor before? Yes No

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

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

Date of 1st treatment _____ Number of treatments in the last 12 months _____

Date of last: Spinal Exam _____ Spinal X-Ray _____ Other 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 Osteoprosis 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 _____	_____	_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate any care and treatment, any fees for professional services rendered will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my conditions deemed appropriate through the use of Chiropractic Health Care, and I give authority for those procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while I am an active patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. Patient may obtain copies of their file and x-rays upon request. Copying fees may apply.

Patient Signature _____ Date _____

Guardian Signature _____ Date _____

Doctor Signature _____ Date _____