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 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 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 or the 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 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 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) ______________________________

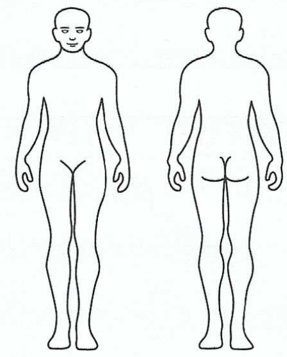
5 PATIENT CONDITION

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 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

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

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day ____________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week ____________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day ____________
☐ Heavy	☐ Heavy Labor	☐ 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		

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MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

Pharmacy Name ____________

Pharmacy Phone (_____) ____________