CHIROPRACTIC REGISTRATION & HISTORY

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Insurance ID # _____

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

PHONE NUMBERS

Home Phone (____) _____ Cell Phone (____) _____

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 _____

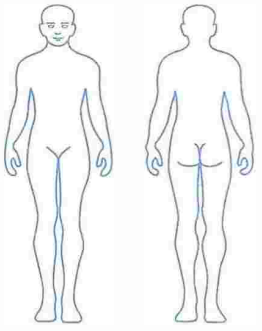
When did your symptoms appear? _____

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

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

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ 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		

MEDICATIONS

_____
_____
_____
Pharmacy Name _____
Pharmacy Phone (____)_____

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

Patient Name_____ Date _____/_____/_____

PATIENT SYMPTOM(S) FORM

Symptom 1 _____

On a scale from 0-10 with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

Did the symptom begin **suddenly** or **gradually** ? (circle one)

How did the symptom begin? _____

What makes the symptom worst? (circle all that apply):

Bending neck forward, bending neck backward, tilting head to the left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, other (please describe):

_____

What makes the symptom better? (circle all that apply):

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe): _____

Describe the quality of the symptom (circle all that apply):

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging

Other (please describe): _____

Does the symptom radiate to another part of your body? (circle one) YES No

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

On a scale from 0-10 with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

Did the symptom begin **suddenly** or **gradually** ? (circle one)

How did the symptom begin? _____

What makes the symptom worst? (circle all that apply):

Bending neck forward, bending neck backward, tilting head to the left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, other (please describe):

_____

What makes the symptom better? (circle all that apply):

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe): _____

Describe the quality of the symptom (circle all that apply):

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging

Other (please describe): _____

Does the symptom radiate to another part of your body? (circle one) YES No

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

Morning Afternoon Evening Night Unaffected by time of day

Symptom 3 _____

On a scale from 0-10 with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

Did the symptom begin **suddenly** or **gradually** ? (circle one)

How did the symptom begin? _____

What makes the symptom worst? (circle all that apply):

Bending neck forward, bending neck backward, tilting head to the left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, other (please describe):

_____

What makes the symptom better? (circle all that apply):

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe): _____

Describe the quality of the symptom (circle all that apply):

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging

Other (please describe): _____

Does the symptom radiate to another part of your body? (circle one) YES No

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 _____

On a scale from 0-10 with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

Did the symptom begin **suddenly** or **gradually** ? (circle one)

How did the symptom begin? _____

What makes the symptom worst? (circle all that apply):

Bending neck forward, bending neck backward, tilting head to the left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, other (please describe):

_____

What makes the symptom better? (circle all that apply):

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe): _____

Describe the quality of the symptom (circle all that apply):

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging

Other (please describe): _____

Does the symptom radiate to another part of your body? (circle one) YES No

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

Morning Afternoon Evening Night Unaffected by time of day