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.

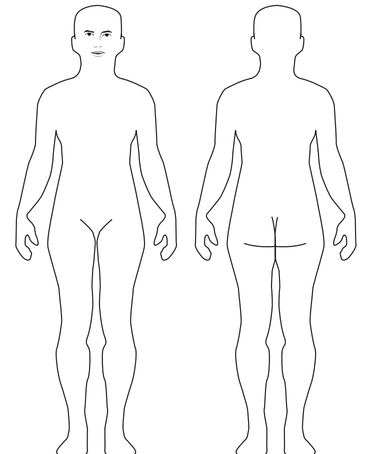
Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) __________

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

- OVER -

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 ay 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 ______