EASTERN SHORE CHIROPRACTIC CENTER REGISTRATION & HISTORY

Patient Information

Date: _____

Social Security # _____

Patient First Name: _____

Patient Middle Initial: _____

Patient Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Sex: ☐ Male ☐ Female Age: _____

Birthdate: _____

MARITAL STATUS ☐ 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? _____

Eastern Shore
Chiropractic Center, Inc.
Gentle Lasting Pain Relief Is Our Specialty

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 certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) 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 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 Companylies) 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

Work Phone: _____ Cell Phone: _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT

Name: _____ Relationship: _____

Cell 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): _____

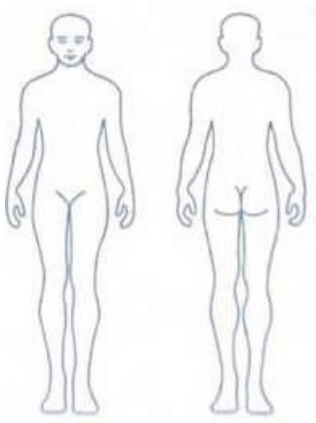
Patient Condition

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 I (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:

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV	◉	○	Diabetes	○	○	Liver Disease	○	○	Rheumatoid Arthritis	○	○
Alcoholism	○	○	Emphysema	○	○	Measles	○	○	Rheumatic Fever	○	○
Allergy Shots	○	○	Epilepsy	○	○	Migraine Headaches	○	○	Scarlet Fever	○	○
Anemia	○	○	Fractures	○	○	Miscarriage	○	○	Sexually Transmitted Disease	○	○
Anorexia	○	○	Glaucoma	○	○	Mononucleosis	○	○	Stroke	○	○
Appendicitis	○	○	Goiter	○	○	Multiple Sclerosis	○	○	Suicide Attempt	○	○
Arthritis	○	○	Gonorrhea	○	○	Mumps	○	○	Thyroid Problems	○	○
Asthma	○	○	Gout	○	○	Osteoporosis	○	○	Tonsillitis	○	○
Bleeding Disorders	○	○	Heart Disease	○	○	Pacemaker	○	○	Tuberculosis	○	○
Breast Lump	○	○	Hepatitis	○	○	Parkinson's Disease	○	○	Tumors, Growths	○	○
Bronchitis	○	○	Hernia	○	○	Pinched Nerve	○	○	Typhoid Fever	○	○
Bulimia	○	○	Herniated Disk	○	○	Pneumonia	○	○	Ulcers	○	○
Cancer	○	○	Herpes	○	○	Polio	○	○	Vaginal Infections	○	○
Cataracts	○	○	High Blood Pressure	○	○	Prostate Problem	○	○	Whooping Cough	○	○
Chemical Dependency	○	◉	High Cholesterol	○	○	Prosthesis	○	○	Other: _____	○	○
Chicken Pox	○	○	Kidney Disease	○	○	Psychiatric Care	○	○	Other: _____	○	○

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 Date of recent immunizations: Type:

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

Medications	Allergies	Vitamins/Herbs/Minerals
Pharmacy Name:		
Pharmacy Phone:		