

# CHIROPRACTIC REGISTRATION AND HISTORY

## 1

### PATIENT INFORMATION

Date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Patient SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 2

### 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, 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

## 3

### PHONE NUMBERS

Home \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_

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) \_\_\_\_\_

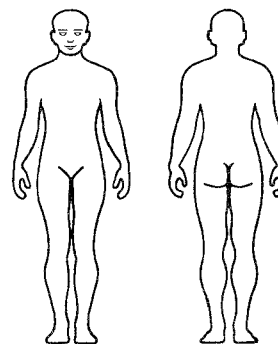
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

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

# 7

## MEDICATIONS

## ALLERGIES

## VITAMINS/HERBS/MINERALS

Pharmacy Name \_\_\_\_\_

Pharmacy Phone \_\_\_\_\_