

PATIENT REGISTRATION

PATIENT INFORMATION	INSURANCE INFORMATION
<p style="text-align: right;">Date _____</p> <p>Name _____</p> <p>Address _____</p> <p>City _____</p> <p>State _____ Zip _____</p> <p>E-mail _____</p> <p>Birthdate: _____</p> <p>Age _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>SS#: _____</p> <p>Employer _____</p> <p>Occupation _____</p> <p>Spouse's Name _____</p> <p>Spouse's Employer _____</p> <p>Who referred you? _____</p> <p>Name of family physician _____</p> <p>May we contact them regarding your health? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Who is responsible for this account? _____</p> <p>Relationship to patient _____</p> <p>Insurance Co.: _____</p> <p>Group #: _____ ID# _____</p> <p>Are you covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Secondary Insurance Co.: _____</p>
ACCIDENT INFORMATION	
<p>Injury due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, Date of accident _____</p> <p>Type of accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other</p> <p>Have you made a report of your accident? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>To Whom? <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Workers' Comp</p> <p><input type="checkbox"/> Other _____</p> <p>Attorney Name (if applicable) _____</p>	

PHONE NUMBERS & EMERGENCY CONTACT

Home _____ Work _____ Cell _____ Best time to reach _____

Emergency Contact Information

Name _____ Relationship _____ Home _____ Work _____

PATIENT CONDITION (HPI)

Reason for visit _____

When did your symptoms start? _____

How did your problem start? _____

Rate your pain level **today**: (please circle one)

0 1 2 3 4 5 6 7 8 9 10

No Pain **Severe Pain**

Is your pain? Constant Frequent Occasional Intermittent

(100% of day) (75% of day) (50% of day) (25% of day)

Describe the pain: Sharp Dull ache Shooting Burning

Stabbing Numbness Tingling Throbbing

Is your condition? Getting Better Staying the same Getting Worse

Does it interfere with? Work Sleep Recreation Daily Activity Nothing

What makes you worse? Sitting Standing Walking Bending Lying down

What makes you better? Nothing Rest Activity Heat Cold Medication

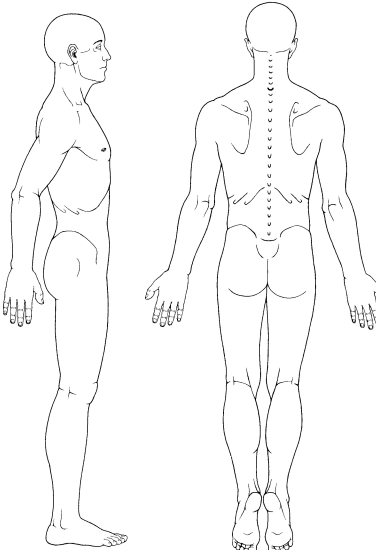
What tests have you had? X-rays MRI EMG Ultrasound Lab work

What treatment have you had? Drugs Nerve blocks PT Surgery

Has the treatment helped? Yes No

Have you ever had this problem before? Yes No

(Please mark your areas of pain)



PATIENT REGISTRATION

SOCIAL HISTORY				
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced / Separated <input type="checkbox"/> Widowed	Use of Alcohol <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Moderate <input type="checkbox"/> Daily	Use of Tobacco <input type="checkbox"/> Never <input type="checkbox"/> Previously, but quit <input type="checkbox"/> Currently _____ Packs per day	Work Activity <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light labor <input type="checkbox"/> Heavy labor	Exercise Activity <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Strenuous

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS please check <input checked="" type="checkbox"/> any that apply to you			
Constitutional <input type="checkbox"/> Bad general health <input type="checkbox"/> Recent weight change <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Headaches Eyes <input type="checkbox"/> Eye disease/injury <input type="checkbox"/> Glasses or contact lens <input type="checkbox"/> Blurred / double vision Ear, Nose, Throat <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Vertigo <input type="checkbox"/> Sinus problems <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sore throat / voice change <input type="checkbox"/> Swollen glands Neurological <input type="checkbox"/> Seizures or Epilepsy <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Tremors <input type="checkbox"/> Stroke	Musculoskeletal <input type="checkbox"/> Joint Pain / Stiffness <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Fibromyalgia Cardiovascular <input type="checkbox"/> Chest pain / Palpitations <input type="checkbox"/> Dizziness / Fainting <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Swelling in hands / feet <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart attack <input type="checkbox"/> Congestive heart failure Gastrointestinal <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Diarrhea/Constipation <input type="checkbox"/> Blood in stools <input type="checkbox"/> Gall bladder problems <input type="checkbox"/> Liver problems <input type="checkbox"/> Ulcers	Genito-urinary <input type="checkbox"/> Pain / Difficulty urinating <input type="checkbox"/> Blood in urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney stones <input type="checkbox"/> Kidney problems Respiratory <input type="checkbox"/> Cough <input type="checkbox"/> Congestion <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumonia Psychiatric <input type="checkbox"/> Anxiety / Depression <input type="checkbox"/> Mood Swings <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Memory loss Hematologic/Lymphatic <input type="checkbox"/> Slow to heal after cuts <input type="checkbox"/> Bleed or bruise easily <input type="checkbox"/> Anemia <input type="checkbox"/> Enlarged glands	Endocrine <input type="checkbox"/> Excessive thirst / urination <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Skin becoming drier <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disorder Integumentary (skin, breast) <input type="checkbox"/> Rash / Sores <input type="checkbox"/> Lesions <input type="checkbox"/> Breast pain or lump <input type="checkbox"/> Dermatitis / Eczema Allergic/Immunologic <input type="checkbox"/> Food allergies <input type="checkbox"/> Airborne allergies <input type="checkbox"/> Systemic Lupus <input type="checkbox"/> Cancer <input type="checkbox"/> HIV/AIDS

FAMILY HISTORY													
	Living?		Rheumatoid Arth		Cancer		Diabetes		Heart Problems		Back Problems		
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brothers/Sisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

LIST HOSPITALIZATIONS AND SURGERIES
Falls _____
Fractures _____
Hospitalizations _____
Surgeries _____

MEDICATIONS	SUPPLEMENTS	ALLERGIES
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION / FINANCIAL AGREEMENT/ ASSIGNMENT

I CERTIFY THAT I (OR MY DEPENDENT) ASSIGN DIRECTLY TO MY CHIROPRACTIC PROVIDER ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED.

I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION REQUESTED BY MY INSURANCE COMPANY TO DOCUMENT MY CLAIM FOR BENEFITS. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR FULL PAYMENT OF ALL CHARGES. PAYABLE AT THE TIME RENDERED.

I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE FORMS.

Signature of patient or parent of minor _____ Date _____