PATIENT REGISTRATION

PATIENT INFORMATION

Date_____

Name_____

Address_____

City_____

State_____ Zip_____

E-mail_____

Birthdate:_____

Age_____ Sex: ☐ Male ☐ Female

SS#:_____ _____ _____

Employer_____

Occupation_____

Spouse's Name_____

Spouse's Employer_____

Who referred you? _____

Name of family physician_____

May we contact them regarding your health? ☐ Yes ☐ No

INSURANCE INFORMATION

Who is responsible for this account?_____

Relationship to patient_____

Insurance Co.:_____

Group #:_____ ID#_____

Are you covered by additional insurance? ☐ Yes ☐ No

Secondary Insurance Co.:_____

ACCIDENT INFORMATION

Injury due to an accident? ☐ Yes ☐ No

If yes, Date of accident _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

Have you made a report of your accident? ☐ Yes ☐ No

To Whom? ☐ Auto Insurance ☐ Employer ☐ Workers' Comp

☐ Other _____

Attorney Name (if applicable)_____

PHONE NUMBERS & EMERGENCY CONTACT

Home_____ Work _____ Cell_____ Best time to reach_____

Emergency Contact Information

Name_____ Relationship_____ Home_____ Work _____

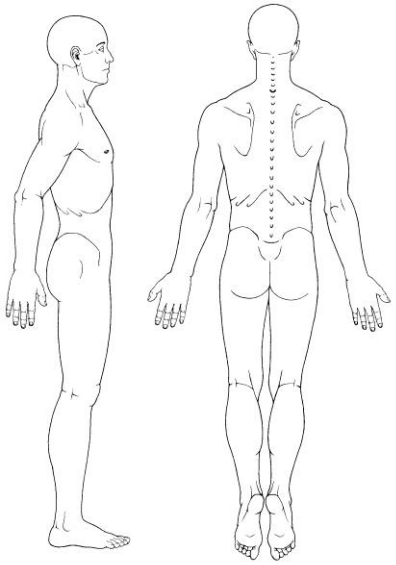
PATIENT CONDITION (HPI)

Reason for visit_____

When did your symptoms start?_____

How did your problem start?_____

(Please mark your areas of pain)



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

PATIENT REGISTRATION

SOCIAL HISTORY

Marital Status	Use of Alcohol	Use of Tobacco	Work Activity	Exercise Activity
☐ Single	☐ Never	☐ Never	☐ Sitting	☐ None
☐ Married	☐ Rarely	☐ Previously, but quit	☐ Standing	☐ Light
☐ Divorced / Separated	☐ Moderate	☐ Currently	☐ Light labor	☐ Moderate
☐ Widowed	☐ Daily	_____ Packs per day	☐ Heavy labor	☐ Strenuous

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS *please check ☑ any that apply to you*

Constitutional
- ☐ Bad general health
- ☐ Recent weight change
- ☐ Fever
- ☐ Fatigue
- ☐ Headaches

Eyes
- ☐ Eye disease/injury
- ☐ Glasses or contact lens
- ☐ Blurred / double vision

Ear, Nose, Throat
- ☐ Hard of Hearing
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Sore throat / voice change
- ☐ Swollen glands

Neurological
- ☐ Seizures or Epilepsy
- ☐ Numbness / Tingling
- ☐ Tremors
- ☐ Stroke

Musculoskeletal
- ☐ Joint Pain / Stiffness
- ☐ Joint Swelling
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Chronic fatigue
- ☐ Fibromyalgia

Cardiovascular
- ☐ Chest pain / Palpitations
- ☐ Dizziness / Fainting
- ☐ Shortness of breath
- ☐ Swelling in hands / feet
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Congestive heart failure

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea/Vomitting
- ☐ Diarrhea/Constipation
- ☐ Blood in stools
- ☐ Gall bladder problems
- ☐ Liver problems
- ☐ Ulcers

Genito-urinary
- ☐ Pain / Difficulty urinating
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Kidney problems

Respiratory
- ☐ Cough
- ☐ Congestion
- ☐ Wheezing
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia

Psychiatric
- ☐ Anxiety / Depression
- ☐ Mood Swings
- ☐ Difficulty sleeping
- ☐ Memory loss

Hematologic/Lymphatic
- ☐ Slow to heal after cuts
- ☐ Bleed or bruise easily
- ☐ Anemia
- ☐ Enlarged glands

Endocrine
- ☐ Excessive thirst / urination
- ☐ Heat or cold intolerance
- ☐ Skin becoming drier
- ☐ Diabetes
- ☐ Thyroid disorder

Integumentary (skin, breast)
- ☐ Rash / Sores
- ☐ Lesions
- ☐ Breast pain or lump
- ☐ Dermatitis / Eczema

Allergic/Immunologic
- ☐ Food allergies
- ☐ Airborne allergies
- ☐ Systemic Lupus
- ☐ Cancer
- ☐ 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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brothers/Sisters	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 UNDERSTAND THERE IS A MINIMUM FEE THAT I MUST PAY REGARDLESS OF EOB/ NETWORK.

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 _____

PATIENT REGISTRATION

HIPAA DISCLOSURE

We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care.

Can we leave messages at home or work?

☐ Yes ☐ No

Please list who may we discuss your health information

1. _____ relationship _____
2. _____ relationship _____
3. _____ relationship _____

Are there other restrictions or disclosures?

_____

_____
Print Name

_____
Signature

_____
Date