# CHIROPRACTIC REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

## 2 INSURANCE INFORMATION

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

_____ and assign directly to
Name of Insurance Company(ies)

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 Company(ies) 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

## 3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

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) _____

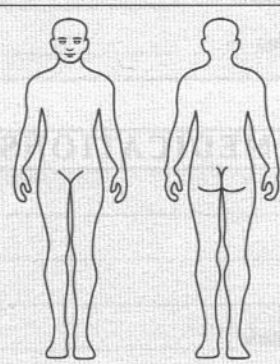
## 5 PATIENT CONDITION

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

## GENERAL SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

### GENERAL
- ☐ Bruise easily
- ☐ Chills
- ☐ Dental problems
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Tiredness
- ☐ Weight gain

### GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

### GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

### CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

### EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – flashes
- ☐ Vision – halos

### SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

### MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

### WOMEN only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

## NECK, BACK, EXTREMITIES Check (✓) symptoms you currently have or have had in the past year.

### NECK
- ☐ Pain in neck
- ☐ Neck stiffness
- ☐ Neck weakness
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding/popping sounds in neck

### SHOULDERS

| | Right | Left |
|---|---|---|
| ☐ Pain in shoulder joint | ☐ R | ☐ L |
| ☐ Pain across shoulders | | |
| ☐ Can't raise arm | ☐ R | ☐ L |
| ☐ Above shoulder level | | |
| ☐ Over head | | |
| ☐ Tension in shoulders | | |
| ☐ Pinched nerve in shoulder | ☐ R | ☐ L |

### MID-BACK
- ☐ Mid-back pain
- ☐ Mid-back stiffness
- ☐ Pain between shoulder blades
- ☐ Pain from front to back
- ☐ Muscle spasms in mid-back

### ARMS & HANDS

| | Right | Left |
|---|---|---|
| ☐ Pain in upper arm | ☐ R | ☐ L |
| ☐ Pain in elbow | ☐ R | ☐ L |
| ☐ Pain in forearm | ☐ R | ☐ L |
| ☐ Pain in hand | ☐ R | ☐ L |
| ☐ Pain in fingers | ☐ R | ☐ L |
| ☐ Pins & needles in arm | ☐ R | ☐ L |
| ☐ Pins & needles in fingers | ☐ R | ☐ L |
| ☐ Numbness in arm | ☐ R | ☐ L |
| ☐ Numbness in fingers | ☐ R | ☐ L |
| ☐ Weakness of arm | ☐ R | ☐ L |
| ☐ Weakness of hand | ☐ R | ☐ L |
| ☐ Hands cold | ☐ R | ☐ L |

### LOW BACK
- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Low back weakness
- ☐ Pinched nerve in low back
- ☐ Low back feels out of place
- ☐ Muscle spasms in low back

### HIPS, LEGS & FEET

| | Right | Left |
|---|---|---|
| ☐ Pain in buttocks | ☐ R | ☐ L |
| ☐ Pain in hip joint | ☐ R | ☐ L |
| ☐ Pain down leg | ☐ R | ☐ L |
| ☐ Pain in knee | ☐ R | ☐ L |
| ☐ Pain in ankle | ☐ R | ☐ L |
| ☐ Pain in foot | ☐ R | ☐ L |
| ☐ Weakness of leg | ☐ R | ☐ L |
| ☐ Weakness of knee | ☐ R | ☐ L |
| ☐ Leg cramps | ☐ R | ☐ L |

### OTHER SYMPTOMS

_____

_____

_____

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient Signature Date

Reviewed by_____ _____

Doctor Date

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