

Registration and History

Today's Date _____

PATIENT INFORMATION

Last Name _____ First _____ Middle Initial _____
 Address _____
 City _____ State _____ Zip _____
 Phone (____) _____ Cell (____) _____ e-mail _____
 Date of Birth _____ Gender: Male Female
 Social Security Number _____ - _____ - _____ Marital Status: Married Single Minor
 Name of Individual Responsible for this account _____
 Whom May we thank for referring you? _____
 Emergency Contact _____ Relationship _____
 Contact Phone _____ Contact Cell _____

EMPLOYER INFORMATION

Occupation _____ / School _____
 Employer _____ Work Phone (____) _____

INSURANCE INFORMATION

Insurance Company _____ Group # _____
 Insurance ID # _____
 Name of Insured _____ Insured's Date of Birth _____
 Relationship to Patient _____ Gender: Male Female
 Insured's Employer _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date of Accident _____
 Type of Accident Auto Work Home Other (If auto, additional information is required)
 To Whom have you made a report of your accident? Auto Ins. Employer Worker Comp. Other
 Attorney Name and phone # (if applicable) _____

ASSIGNMENT OF BENEFITS AND RELEASE

I certify that I, and/or my dependent(s), 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 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 _____
 Printed Name of Patient, Parent, Guardian or Personal Representative _____
 Relationship to Patient (if other than patient) _____ Date of Signature _____

PATIENT CONDITION

Reason for Visit _____
 When did your symptoms appear? _____

Mark an "X" on the picture (at right) where you continue to have pain numbness, or tingling.

Is this condition getting progressively worse? Yes No Unknown
 Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

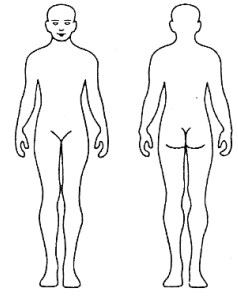
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning
 Tingling Cramps Stiffness Swelling Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: (circle one) 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:

<input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Alcoholism <input type="checkbox"/> Allergy Shots <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fractures <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herniated Disk <input type="checkbox"/> Herpes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pacemaker <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Pinched Nerve <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Prostate Problem <input type="checkbox"/> Prosthesis <input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Sexually Transmitted Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Tumors, Growths <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Whooping Cough Other _____ _____ _____
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EXERCISE <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	WORK ACTIVITY <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	HABITS <input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Coffee/Caffeine Drinks <input type="checkbox"/> High Stress Level	Packs/Day _____ Drinks/Week _____ Cups/Day _____ Reason _____
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Are you pregnant? Yes No Due Date _____

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

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

