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) ______

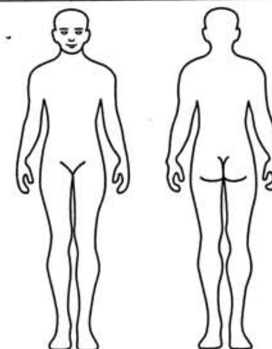
5 PATIENT CONDITION

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

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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:

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

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day ______
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week ______
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day ______
☐ Heavy	☐ Heavy Labor	☐ 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	______	______

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

Auto Accident Information

Patient Name:_______________________________________Acct #:______________

1. Chief Complaint:

Describe your current complaint that you are requesting evaluation and treatment for from this office:____
____
____

Please check the symptoms you are experiencing since the auto accident:

____ Headaches	____ Clicking/Popping Jaw	____ Dizziness
____ Neck Pain/Stiffness	____ Chest Pain	____ Fainting
____ Mid Back Pain	____ Breath Shortness	____ Loss of Balance
____ Low Back Pain	____ Sleeping Problems	____ Loss of Memory
____ Arm Pain	____ Fatigue	____ Numbness in Fingers
____ Leg Pain	____ Depression	____ Numbness in Toes
____ Muscle Spasm/Cramping	____ Pain Behind Eyes	____ Ringing/Buzzing
____ Pain across Shoulder Blades	____ Eyes Light Sensitive	____Irritability
____ Arm/Leg Weakness	____ Cold Hands	____ Diarrhea
____ Facial Pain	____ Cold Feet	____ Constipation

2. Accident History:

Date of the accident: __________ Time:__________ AM/PM

Name of the driver of the vehicle: ______________________________________

Where were you seated in the vehicle? ___________________________________

Year, Make & Model of the vehicle: ______________________________________

Type of Accident: ____ Head-on Collision ____Broad-side Collision ____Front Impact
____ Rear-end car in front of you ____ Non-Collision ____Rear Impact

Please describe the accident in your own words: (Be very specific!!)__________
____
____
____

Was your car moving at the time of the accident? __________
If yes, how fast would you estimate you were going? __________Mph

Your Head and Body position at time of impact:

____Head Turned Left	____ Head Turned Right	____Body Straight
____Head Looking Back	____ Body Rotated Right	____ Body Rotated Left
____ Head Straight Forward	____ Other: ___________	

Year, Make & Model of the **OTHER** vehicle: _________________________________

How fast do you estimate the **OTHER** car was going? ________Mph

Were you wearing your seat belt? ____ Yes ____ No
Did you see the accident coming? ____ Yes ____ No
Did you brace yourself for the impact? ____ Yes ____ No
Upon impact, do you recall striking any objects inside of the car? ____ Yes ____ No
If yes, what objects did you strike? ____________________
Road conditions at time of accident:
____ Icy ____ Rainy ____ Wet
____ Clear ____ Dark ____ Other: __________
Visibility at the time of the accident:
____ Poor ____Fair ____Good
Where was your car struck? ____________________
Were you wearing a hat or glasses? ____Yes ____ No
If yes, where were they located after the accident? ____________________
Did you get any bleeding cuts? ____ Yes ____ No
If yes, where? ____________________
Did you get any bruises? ____ Yes ____ No
If yes, where? ____________________
As a result of the accident were you:
____ Rendered Unconscious ____ In Shock ____ Dazed, Circumstances Vague
____ Other: ____________

3. Treatment History:

Did you seek medical help immediately after the accident? ____ Yes ____ No
If yes, where? ____________________
If yes, how did you get there?
____ Ambulance ____ Police ____ I drove own car
____ Someone else drove me ____ Other: ____________________

Who was the first doctor that treated you? ____________________
Date seen:__________
Were you examined? ____ Yes ____ No
Were X-rays taken? ____ Yes ____ No
Did you receive treatment? ____ Yes ____ No
If yes, what kind: ____ Medications ____Braces ____Collars
What benefits did you receive from the treatment? ____________________

Since the accident, are symptoms becoming: ____ Better ____ Worse ____Same
Describe your symptoms: ____Constant ____ Intermittent
What relieves your symptoms? ____________________
What aggravates your symptoms? ____________________