## **CHIROPRACTIC REGISTRATION AND HISTORY**

PATIENT INFORMATION	INSURANCE INFORMATION
Date	
SS/HIC/Patient ID #	Who is responsible for this account?
Patient Name	Insurance Co
Last Name	Group #
First Name Middle Initial	
Address	Is patient covered by additional insurance? Yes No
E-mail	Subscriber's Name
City	Birthdate SS#
State Zip	Relationship to Patient
Sex M F Age	Insurance Co.
Birthdate	Group #
☐ Married ☐ Widowed ☐ Single ☐ Minor	ASSIGNMENT AND RELEASE I certify that I, and/or my dependent(s), have insurance coverage with
☐ Separated ☐ Divorced ☐ Partnered for years	Name of Insurance Company(ies) and assign directly to
Patient Employer/School	Dr. all insurance benefits, if
Occupation	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
Employer/School Address	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
Employer/School Phone ()	for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when
Spouse's Name	my current treatment plan is completed or one year from the date signed below.
Birthdate	
SS#	Signature of Patient, Parent, Guardian or Personal Representative
Spouse's Employer	Please print name of Patient, Parent, Guardian or Personal Representative
Whom may we thank for referring you?	
	Date Relationship to Patient
3 PHONE NUMBERS	ACCIDENT INFORMATION
Cell Phone () Home Phone ()	Is condition due to an accident?   Yes   No Date
Best time and place to reach you IN CASE OF EMERGENCY, CONTACT	Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other
Name Relationship	To whom have you made a report of your accident?  ☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other
Home Phone () Work Phone ()	Attorney Name (if applicable)
PATIENT CONDITION	
Reason for Visit	
When did your symptoms appear?	( o o)
Is this condition getting progressively worse?  Yes  No Unknown	
Mark an X on the picture where you continue to have pain, numbness, or	
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe Type of pain:   Sharp  Dull  Throbbing  Numbness	
	Swelling
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 ☐ F	Recreation )   ( )   (
Activities or movements that are painful to perform ☐ Sitting ☐ Standing	g □ Walking □ Rending □ Lying Down

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down

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What treatment have you already received for your condition	HEALTH HI	STORY		CIDDA:				
Chiropractic Services   None   Other	What treatment have you alread	received for your condition?	☐ Medications	s Surgery D	Dhysical Thorany			
Name and address of other doctor(s) who have treated you for your condition			iviedications	s 🗌 Surgery 📋	Physical Therapy			
Date of Last:   Physical Exam								
Spinal Exam								
Dental X-Ray	Date of Last: Physical Exam_	Spir	al X-Ray		Blood Test			
Place a mark on "Yes" or "No" to indicate if you have had any of the following:	Spinal Exam	Che	st X-Ray		Urine Test			
AlDS/HIV	Dental X-Ray	MRI	, CT-Scan, Boi	ne Scan				
Alcoholism	Place a mark on "Yes" or "No" to	indicate if you have had any o	of the following	:				
Allergy Shots	AIDS/HIV Yes	No Diabetes	Yes 🗆 No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes	□No
Anemia	Alcoholism Yes	No Emphysema	Yes 🗌 No	Measles	☐ Yes ☐ No	Scarlet Fever	Yes	□No
Anorexia	Allergy Shots Yes	No Epilepsy	Yes 🗌 No	Migraine Headaches	s ☐ Yes ☐ No			
Anorexia	Anemia Yes	No Fractures	Yes No	Miscarriage	☐ Yes ☐ No		□Yes	□No
Appendicitis	Anorexia Yes	No Glaucoma	Yes 🗌 No	Mononucleosis	☐ Yes ☐ No	Stroke		
Arthritis	Appendicitis Yes	No Goiter	Yes No	Multiple Sclerosis	☐ Yes ☐ No			
Asthma	Arthritis Yes	No Gonorrhea	Yes No	Mumps	☐ Yes ☐ No			
Bleeding Disorders   Yes   No	Asthma Yes	lo Gout	Yes No	Osteoporosis	☐ Yes ☐ No			
Breast Lump	Bleeding Disorders  Yes	No Heart Disease	Yes No	Pacemaker	☐ Yes ☐ No	Tuberculosis		
Bulimia	Breast Lump  Yes	No Hepatitis	Yes No	Parkinson's Disease	e 🗌 Yes 🔲 No	Tumors, Growths		
Cancer	Bronchitis Yes	lo Hernia	Yes No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever		□No
Cataracts	Bulimia Yes		Yes No	Pneumonia	☐ Yes ☐ No	Ulcers	Yes	□No
Chemical Dependency   Yes   No Dependency   Yes			Yes No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes	□No
Chemical Dependency   Yes   No   High Cholesterol   Yes   No   Psychiatric Care   Yes   No   Psychiatric Care   Yes   No   Rheumatoid Arthritis   Yes   No   Rheumatoid Arthritis   Yes   No   No   Psychiatric Care   Yes   No   No   Rheumatoid Arthritis   Yes   No   Rheumatoid Arthritis   Yes   No   No   Psychiatric Care   Yes   No   No   Rheumatoid Arthritis   Yes   No   No   Psychiatric Care   Yes   No   No   No   No   No   No   No   N			Yes □ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	□Yes	□No
Chicken Pox								
EXERCISE   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   Falls   Head Injuries   Falls     The sum of the su								
Sitting Smoking Packs/Day Dinks/Week Standing Alcohol Drinks/Week Cups/Day Heavy Are you pregnant? Yes No Due Date  Injuries/Surgeries you have had Falls Head Injuries Heavy Standing Stress Level Reason Date    Smoking Smoking Packs/Day Drinks/Week     Coffee/Caffeine Drinks Cups/Day     Heavy Labor   High Stress Level   Reason     Date   Date     Date   Date     Head Injuries   Date     Head Injuries   Date     Date   Date				Rheumatoid Arthritis	Yes No			
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  Date  Falls  Head Injuries	EXERCISE	WORK ACTIVITY		HABITS				
Daily	□ None	Sitting		☐ Smoking	Packs	/Day		
Heavy Labor High Stress Level Reason  Are you pregnant? Yes No Due Date  Injuries/Surgeries you have had Description Date  Falls Head Injuries	□ Moderate	☐ Standing		☐ Alcohol	Drinks	s/Week		
Are you pregnant?	☐ Daily	☐ Light Labor						
Injuries/Surgeries you have had Description Date Falls Head Injuries	Heavy	☐ Heavy Labor						
Injuries/Surgeries you have had Description Date Falls Head Injuries								
Falls Head Injuries	Are you pregnant? ☐ Yes ☐	lo Due Date						
Falls Head Injuries	Injuries/Surgeries you have had	D.	ecription			Data		
Head Injuries		Б	25CHPtIOH			Date		
Broken Bones	Head Injuries							
	Broken Bones							
Dislocations	Dislocations							
Surgeries	Surgeries				The state of the s			
MEDICATIONS ALLERGIES VITAMINS/HERBS/MINERALS	MEDICAT	ONS	ATTE	DCIEC	TITTA BETRIC	/IIIIDDO /34	# %   T   T	AVC
MEDICATIONS ALLERGIES VITAMINS/HERBS/MINERALS	MEDICAL	ONS	ALLEI	RGIES	VIIAMINS	HEKBS/M	INER	ALS
Pharmacy Name								
Pharmacy Phone ()	Pharmacy Name							