Dr. Robert E. Cole – Chiropractic & Nutrition

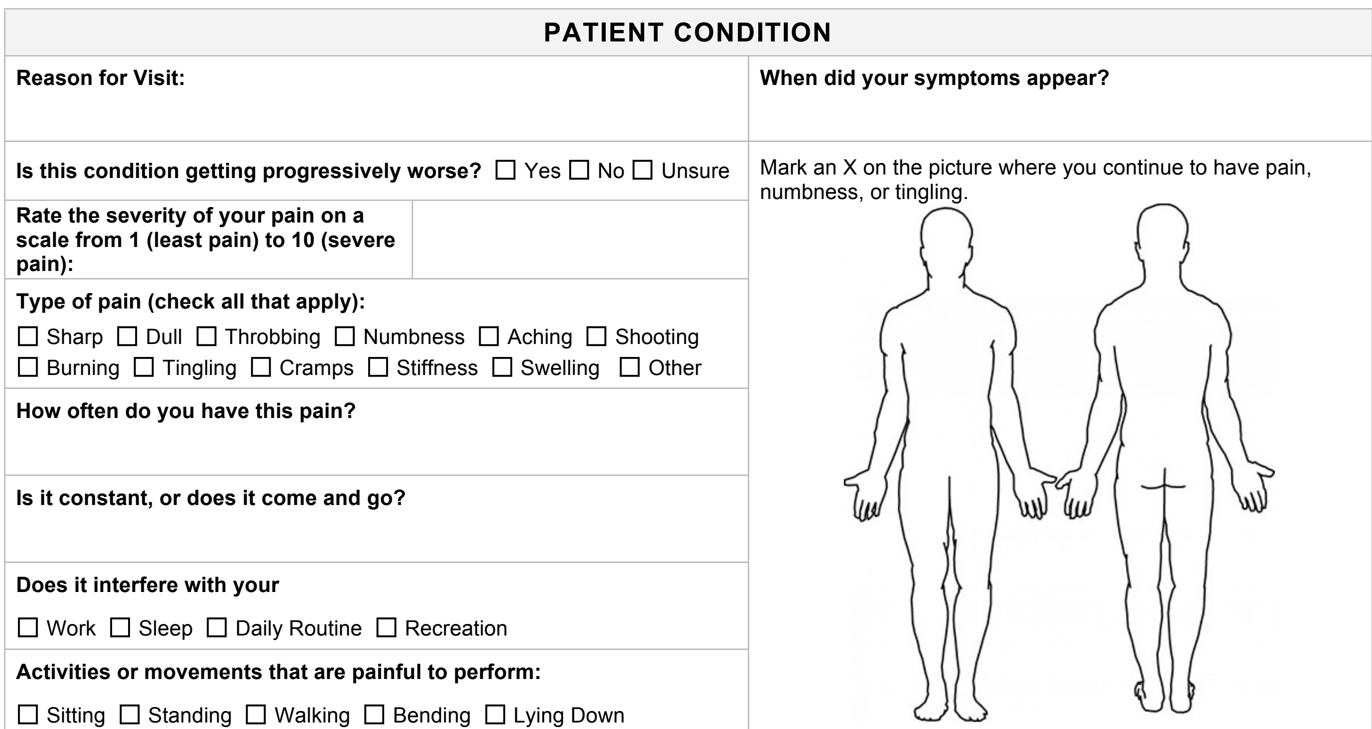
4055 Monroeville Blvd. Suite 130 | Monroeville, PA 15146 | (412) 856-9001

REGISTRATION FORM

(Please Print)

Today's date:				
PATIENT INFORMATION				
Patient's last name: **First:** **Middle:**		**Title:** ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	**Marital status (check one)** ☐ Single ☐ Married ☐ Div ☐Sep ☐Wid	
Is this your legal name? ☐ Yes ☐ No	**If not, list your legal name:**	**(Former name):**	**Birth date:** **Age:**	**Sex:** ☐ M ☐ F
Street address:		**Email:**	**Home phone:**	
City:	**State:**	**ZIP Code:**	**Work phone:**	
Occupation:	**Best time & place to reach you:**		**Cell phone:**	
Employer/School:	**Employer/School Address:**		**Employer/School phone no.:**	
Spouse's Name:	**Spouse's Birth date:**	**Spouse's Employer:**	**Who may we thank for referring you?**	

IN CASE OF EMERGENCY			
Emergency Contact:	**Relationship to Patient:**	**Home phone:**	**Alternate phone:**



PATIENT CONDITION	
Reason for Visit:	**When did your symptoms appear?**
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unsure	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 (check all that apply): ☐ 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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INSURANCE INFORMATION

(This section can be omitted if a copy of the responsible party's insurance card is included)

Who is responsible for this account?

Relationship to Patient:	**Birth date:**	**Address (if different):**	**Phone no.:**

Occupation:	**Employer:**	**Employer address:**	**Employer phone no.:**

Is this patient covered by insurance? ☐ Yes ☐ No	**Insurance Co.:**

Subscriber's name:	**Subscriber's SSN:**	**Birth date:**	**Group number:**	**Policy number:**

Name of secondary ins. (if applicable):	**Subscriber's name:**	**Relationship to Patient:**

Group number:	**Policy number:**	**Birth date:**	**Subscriber's SSN:**

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above-named Insurance Copany(ies) and assign directly to Dr. Robert. E. Cole 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.

Dr. Robert E. Cole may use my health care information and may disclose such information to the above-named Insurance Copany(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:	**Print name of Patient, Parent, Guardian or Personal Representative:**
Date:	**Relationship to Patient:**

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No	**Date:**	**Attorney Name (if applicable):**

To whom have you made a report of your accident? (choose one)	**Type of accident (circle one)**
☐ Auto Ins. ☐ Employer ☐ Worker Comp ☐ Other	☐ Auto ☐ Work ☐ Home ☐ Other

HEALTH HISTORY

What treatment have you already received for your condition?	☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other
Name & Address of other doctor(s) who have treated you for this condition?	

Enter Dates of Last:

Physical Exam:	Spinal X-Ray:	Blood Test:
Spinal Exam:	Chest X-Ray:	Urine Test:
Dental X-Ray:	MRI, CT-Scan, or Bone Scan:	

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HEALTH HISTORY

Have you had any of the following?

☐ AIDS/HIV	☐ Diabetes	☐ Liver Disease	☐ Rheumatoid Arthritis
☐ Alcoholism	☐ Emphysema	☐ Measles	☐ Rheumatic Fever
☐ Allergy Shots	☐ Epilepsy	☐ Migraine Headaches	☐ Scarlet Fever
☐ Anemia	☐ Fractures	☐ Miscarriage	☐ Sexual Transmitted Disease
☐ Anorexia	☐ Glaucoma	☐ Mononucleosis	☐ Stroke
☐ Appendicitis	☐ Goiter	☐ Multiple Sclerosis	☐ Suicide Attempt
☐ Arthritis	☐ Gonorrhea	☐ Mumps	☐ Thyroid Problems
☐ Asthma	☐ Gout	☐ Osteoporosis	☐ Tonsillitis
☐ Bleeding Disorders	☐ Heart Disease	☐ Pacemaker	☐ Tuberculosis
☐ Breast Lump	☐ Hepatitis	☐ Parkinson's Disease	☐ Tumors, Growths
☐ Bronchitis	☐ Hernia	☐ Pinched Nerve	☐ Typhoid Fever
☐ Bulimia	☐ Herniated Disk	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Herpes	☐ Polio	☐ Vaginal Infections
☐ Cataracts	☐ High Blood Pressure	☐ Prostate Problem	☐ Whooping Cough
☐ Chemical Dependency	☐ High Cholesterol	☐ Prosthesis	☐
☐ Chicken Pox	☐ Kidney Disease	☐ Psychiatric Care	☐

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

List Injuries/Surgeries you have had	Description	Date
Falls:		
Head Injuries:		
Broken Bones:		
Dislocations:		
Surgeries:		

MEDICATIONS	ALLERGIES	VITAMINS/SUPPLEMENTS
Pharmacy Name:		
Pharmacy Phone:		