PATIENT REGISTRATION

NAME________________________________ HOME PHONE: _______________

ADDRESS ____
STREET CITY STATE ZIP CODE

AGE_____________ BIRTH DATE ___/____/_____ MARITAL STATUS: M S W D

OCCUPATION ______________________ EMPLOYER ___________________

ADDRESS ____
STREET CITY STATE ZIP CODE

OFFICE PHONE ______________________

NAME OF SPOUSE _____________________________

OCCUPATION ______________________ EMPLOYER ___________________

ADDRESS ____
STREET CITY STATE ZIP CODE

OFFICE PHONE ______________________

PATIENT'S NEAREST RELATIVE ____

ADDRESS _____________________________________PHONE________________

INSURANCE INFORMATION

NAME OF PERSON RESPONSIBLE FOR PAYMENT _____________________

PHONE ______________ RESPONSIBLE PARTY 'S DATE OF BIRTH: ___________________

ARE YOU INSURED? ______YES ________NO

COMPANY __________________________________ PHONE ____________________________

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN AGREEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT DR. HENDERSON'S OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO DR. HENDERSON'S OFFICE WILL BE CREDITED TO MY ACCOUNT ON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

I ALSO UNDERSTAND THAT PAYMENT FOR CO-PAYS AND DEDUCTIBLES ARE DUE AT DATE OF SERVICE.

PATIENT'S SIGNATURE ____________________________________ DATE __________________

Henderson Chiropractic
Dr. Robert S. Henderson D.C.

Patient Name____ Today's Date ___________

Age ___________ Birth date _______________ Date of last physical examination _______________

What is your reason for visit? ____

Symptoms **CIRCLE** the symptoms you currently have or have had in the past

GENERAL
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of Sleep
Loss of weight
Nervousness
Numbness
Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
Arms Hips
Back Legs
Feet Neck
Hands Shoulders

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

GASTROINTESTINAL
Appetite Poor
Bloating
Bowel changes
Constipation
Diarrhea
Excessive hunger
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 heartbeat
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

WOMEN Only
Abnormal pap smear
Breast lump
Extreme menstrual pain
Hot Flashes
Other ____________
Date of last menstrual period ____________
Date of last Pap smear ________
Have you had a mammogram? _______
Are you pregnant?______
Number of children _____

CONDITIONS **CIRCLE** the symptoms you currently have or have had in the past

Aids
Alcoholism
Anemia
Anorexia
Appendicitis
Arthritis
Asthma
Bleeding Disorders
Breast lump
Bronchitis
Bulimia
Cancer
Cataracts
Chemical Dependency
Chicken Pox
Diabetes
Emphysema
Epilepsy
Glaucoma
Goiter
Gonorrhea
Gout
Heart Disease
Hepatitis
Hernia
Herpes
High Cholesterol
HIV Positive
Kidney Disease
Liver Disease
Measles
Migraine Headaches
Miscarriage
Mononucleosis
Multiple Sclerosis
Mumps
Pacemaker
Pneumonia
Polio
Prostate Problem
Psychiatric care
Rheumatic Fever
Scarlet Fever
Stroke
Suicide Attempt
Thyroid Problems
Tonsillitis
Tuberculosis
Typhoid Fever
Ulcers
Vaginal infections
Venereal Disease

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MEDICATIONS List medications your are currently taking. **ALLERGIES**

____ ____________________________________
____ ____________________________________
____ ____________________________________
____ ____________________________________

HEALTH HISTORY

FAMILY HISTORY fill in health information about your family.

Relation Age State of health Age of death Cause of death

Father ____
Mother ____
Brothers ____
____
____
Sisters ____
____
____

Circle if your blood relatives had any of the following

Disease Relationship to you.

Arthritis ______________________
Asthma ______________________
Cancer ______________________
Chemical Dependency __________
Diabetes ______________________
Heart Disease, Strokes __________
High Blood Pressure ____________
Kidney Disease ________________
Tuberculosis __________________

HOSPITALIZATIONS

Year Hospital Reason for Hospitalization and Outcome

____
____
____
____
____
____

PREGNANCIES

YEAR OF BIRTH SEX OF BIRTH COMPLICATIONS IF ANY

____
____
____
____

HEALTH HABITS

Circle which substances you use and describe how much you use.

Caffeine ______________________
Tobacco ______________________
Drugs ________________________
Other ________________________

OCCUPATIONAL

Circle if your work exposes you to the following:

Stress Hazardous Substances
Heavy Lifting Other ____________
Occupation _______________________

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 staff responsible for any errors or omissions that I may have made in the completion of this form.

____ ______________________________
Signature Date