CRANE CHIROPRACTIC PATIENT REGISTRATION AND HISTORY

***** PLEASE PRESENT INSURANCE CARD(s) AT THE FRONT DESK *****

Patient Name_____**Nickname**_____

Address_____**City**_____

State_____ **Zip**_____ **Gender** M ___ F ___ Other _____ **Birth Date** _____**SS#**_____

Employer_____ **Occupation** _____

Relationship Status S ___ M ___ D ___ W ___ **Spouse/Partner Name**_____

Please furnish all contact numbers that we are permitted to use and check either Y/N if messages may be left concerning appointments, insurance or general care, if we do not speak to you directly.

Home #_____ Y___N___ **Work#**_____ Ext_____ Y____ N____

Cell#_____ Y___N___ **E-mail**_____ Y___ N___

Emergency #_____Y___N___ **Emergency Name**_____

Reason for Today's Visit_____

Is condition due to an accident/injury? Auto ___ Work ___ Home ___ Other ___ Date_____

Date symptoms appeared_____ **Is this condition getting progressively worse**? Y____ N____

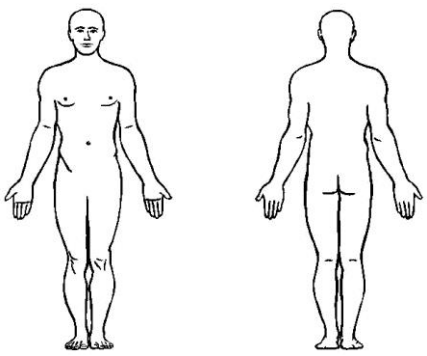
Rate your pain: 0 (none) to 10 (severe) _____ Is the pain: Constant ___ Intermittent ___

Do your symptoms interfere with: Daily Routine ___ Work ___ Recreation ___ Sleep ___ Other _____

Activities that are painful: Sitting ___ Standing ___ Bending ___ Walking ___ Lying Down ___ Lifting ___

What treatment(s) have you received for this condition? Chiropractic ___ Physical Therapy ___ None ___
Surgery ___ Medication ___ Name of Medication(s) _____
Other_____

Name of Doctor(s) who have treated you for this condition_____



Place an X on the drawing where you feel pain, numbness or tingling

Previous chiropractic care? Y____N___ Last Visit_____ Dr.'s Name_____

Date of last: Physical Exam_____ Spinal Exam_____ Spinal X-ray_____ MRI_____
CT Scan_____ Bone Scan_____ Other Testing_____

How did you hear about us? _____ May we thank them? Y___ N___

Are you Pregnant? Yes___ Due Date _____ No_____ Date of Last Menstrual Cycle _____

Place an X on the line <u>AFTER</u> the item(s) below to indicate if you have/had any of the following:
Acid Reflux ___ ADD/ADHD ___ AIDS/HIV ___ ALS ___ Anemia ___ Anorexia ___ Appendicitis ___
Arthritis ___ (Type) _____ Asthma ___ Autism ___ Bleeding Disorders ___ Bronchitis ___Bulimia ___
Cancer ___ (Type)_____ Cataracts ___ Celiac Disease ___ COPD ___ COVID-19 ___
COVID-19 Shot ___ (Date) _____ Colitis ___ Crohn's Disease ___ Diabetes ___ (Type)_____
Digestive Issues ___ Emphysema ___ Epilepsy ___ Gallbladder Issues ___ Glaucoma ___ Gout ___
Heart Disease ___ Hepatitis ___ (Type) _____ Hernia ___ (Type) _____ Herniated Disc ___
High Blood Pressure ___ High Cholesterol ___ Kidney Issues ___ Liver Disease ___Low Blood Pressure ___
Lyme Disease ___ Migraine ___ Mononucleosis ___ Multiple Sclerosis ___ Osteopenia ___ Osteoporosis ___
Pacemaker ___ Parkinson's ___ Pinched Nerve ___ Pneumonia ___ Polio ___ Prostate Issues ___Prosthesis ___
Shingles ___ Skin Disorders ___ Stroke ___ Thyroid Issues ___ Tuberculosis ___Tumors ___ Ulcers ___
Whooping Cough ___ Other_____

ALLERGIES_____
MEDICATIONS _____
_____
VITAMIN/MINERAL/HERBAL SUPPLEMENTS_____
_____

TRAUMA HISTORY: Describe and date any injuries or surgeries you have ever had:
Auto/Motorcycle_____ Date _____
Home/Work _____ Date _____
Sports _____ Date _____
Slips/Falls _____ Date _____
Broken/Dislocated Bones _____ Date_____
Back, Head or Joint Injuries _____ Date _____
Surgeries _____ Date _____

LIFESTYLE PROFILE: **Exercise**: None____Moderate____Daily____Heavy____Type_____
Work Activity: Sitting___ Standing___ Computer___ Lifting ___ **Manual labor**; Heavy ___ Light_____
Sports: _____ **Stress Level:** High___ Med___ Low___ Reason _____
Alcohol: Y___N___ Amt_____ **Caffeinated Drinks**: Y___N___ Amt_____ **Smoking:** Y___N___ Amt_____

I HEREBY ASSIGN ALL INSURANCE BENEFITS FOR SERVICES RENDERED DIRECTLY TO CRANE CHIROPRACTIC AND AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE BILLINGS.
I UNDERSTAND THAT COPAYS, CO-INSURANCE, DEDUCTIBLES, AND BENEFIT LIMITS MAY APPLY; THEREFORE, I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY INSURANCE.

I HEREBY ACKNOWLEDGE THAT I UNDERSTAND ALL FORMS AND INFORMATION REQUESTED AND HAVE GIVEN TRUE AND ACCURATE INFORMATION. I FURTHER UNDERSTAND THAT IT IS MY RESPONSIBILITY TO ADVISE CRANE CHIROPRACTIC OF ANY CHANGES IN MY INFORMATION AS SOON AS POSSIBLE.

X_____ _____
SIGNATURE OF PATIENT/GUARDIAN **DATE**