Dr. Chang (Richard) S. Kim, D.C.

Patient Registration

Patient Information: Please check one in ( ).

Title: ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Dr. Sex: ( ) Male ( ) Female

First Name: ______________________________ Middle Initial: _______ Last Name: _____________________

Address:
____

____

Home Phone #: (________) _______-___________Work Phone #: (_______) _____)_____- _____________

Cell Phone #: (__________) _________- ________________

Date of Birth: _______/_________/____________Email: ____

Social Security #: _________-_________-___________

Marital Status: ( ) Single ( ) Married ( ) Other

Employment Status: ( ) Employed, Occupation? _____________________________________

( ) Student, Which School? ____________________________________

( ) Other

How did you hear about us?: ( )Website ( )Newspapers ( )Yellow pages ( )Referrals ( ) Attorney

( ) Family or Friend ( ) Other

Spouse Information

First Name: _______________________ Middle I: ________ Last Name: _______________________

Emergency Contact

Contact Person: _________________________________ Relationship: ________________________

Phone # of Person Above: ______________________________

Insurance Information

Subscriber's Name: ____ Date of Birth: ____/____/________

Relationship to Patient: ________________________________

Insurance Company: ____ Group #: ____________________

Are You Covered by Additional Insurance? ( ) Yes ( ) No

Subscriber's Name: _______________________________________ Date of Birth: _____/_____/_______

Relationship to Patient: ____________________________

Insurance Company: _____________________________________ Group #: ______________________

Assignment and Release

I, or my dependent, have insurance coverage with _____________________, and assign directly to Richard Kim Chiropractic P.C. all insurance benefit or service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider, Dr. Chang (Richard) Kim D.C., to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party: ____ Date: ________________________

Employer Information

Name: ______________________________________

Address: _______________________________________

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Phone #: _______________________________________

Health History/ Medical Condition: Have you had (or currently) any of the following

If you select 'Other', please explain or describe

( ) Alcoholism
( ) Anemia
( ) Anorexia/ Bulimia
( ) Arthritis
( ) Asthma
( ) Back/ Neck pain
( ) Bleeding Disorder
( ) Breast Lump
( ) Cancer
( ) Chemical Dependency
( ) Chicken Pox
( ) Depression/ Anxiety
( ) Diabetes
( ) Emphysema
( ) Epilepsy
( ) Eye Condition
( ) Fibromyalgia
( ) Fracture
( ) Gall bladder Disease
( ) Gout
( ) Headaches
( ) Heart/ Vascular Disease
( ) Hepatitis
( ) Hernia
( ) Herniated Disc
( ) High Blood Pressure
( ) High Cholesterol
( ) Kidney Disease
( ) Liver Disease
( ) Lupus
( ) Lyme Disease
( ) Miscarriage
( ) Multiple Sclerosis
( ) Neurological Condition
( ) Osteoporosis
( ) Pacemaker
( ) Parkinson's Disease
( ) Pinched Nerve
( ) Polio
( ) Prostate Problem
( ) Prosthesis
( ) Psychiatric Illness
( ) Scoliosis
( ) Skin Disorder
( ) Stroke
( ) Thyroid Problem
( ) Tuberculosis
( ) Ulcers
( ) Urinary Tract Infection
( ) Venereal Disease
( ) Other

Such as:

Surgery History

( ) Abdominal/ Gastrointestinal
( ) Back Surgery
( ) Cardiovascular Procedure
( ) Gynecological/ Genitourinary
( ) Joint Procedure
( ) Neck Surgery
( ) Prostate/ Genitourinary
( ) Skin Procedure

If you have different surgery histories, which are not stated above, please describe:

Allergies

( ) Environmental
( ) Food
( ) Latex
( ) Medication
( ) Seasonal
( ) Other
( ) Other

Social History

( ) Caffeine: Never Moderately Frequently
( ) Alcohol: Never Moderately Frequently
( ) Exercise: Never Moderately Frequently
( ) Tobacco: Never Moderately Frequently
( ) Stress: Never Moderately Frequently
( ) Other:

Family History

( ) Arthritis
( ) Cancer
( ) Cholesterol
( ) Diabetes

( ) Heart Problem ( ) High Blood Pressure ( ) Psychiatric ( ) Stroke
( ) Thyroid ( ) Other ( ) Other

Medication& Substance Use/ Exposure

( ) Alcohol
( ) Intravenous Drug/ Medication
( ) Second Hand Smoke
Oral Drugs/ Medication:

( ) Inhaled Drugs/ Medications
( ) Occupational
( ) Other
Oral Drugs/ Medication:

Daily Activities

( ) Sitting:	Never	Moderately	Frequently	( ) Standing:	Never	Moderately	Frequently
( ) Walking:	Never	Moderately	Frequently	( ) Bending:	Never	Moderately	Frequently
( ) Light Lifting:	Never	Moderately	Frequently	( ) Machinery:	Never	Moderately	Frequently
( ) Heavy Lift:	Never	Moderately	Frequently	( ) Overhead:	Never	Moderately	Frequently
( ) Reaching:	Never	Moderately	Frequently	( ) Computer:	Never	Moderately	Frequently

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

= Numbness, X = Burning, / = Stabbing, 0 = Pins & Needles, + = Dull Ache, S = Sharp

Briefly describe your symptom: ____

When did your symptoms start? Month ____________ Day __________ Year ________________

How did your symptoms begin? ____

Is this due to an accident? ( ) Yes ( ) No Date of the accident: _____________________

Type of accident ( ) Auto ( ) Work ( ) Home ( ) Other ______________________

How often do you experience your symptom?

( ) Constant ( ) Frequent ( ) Occasional ( ) intermittently

Is your symptom currently: ( ) Getting better ( ) Not changing ( ) Getting worse

Indicate the average intensity of your symptoms (0 = None to 10 = unbearable)

( ) 0 ( ) 1 ( ) 2 ( ) 3
( ) 4 ( ) 5 ( ) 6 ( ) 7
( ) 8 ( ) 9 ( ) 10

Is your symptom aggravating with your normal work?

( ) Not at all ( ) A little bit ( ) Moderately ( ) Moderate to severe ( ) Extremely

In general, your overall health right now is:

(   ) Excellent   (   ) Very good   (   ) good   (   ) Fair   (   ) Poor

Who have you seen for this symptoms? When? How long?

(   ) No one   (   ) other chiropractor   (   ) Medical doctor   (   ) physical therapist   (   ) Others

What tests have you had for your symptoms? When?

(   ) X-rays   (   ) MRI   (   ) CT scan   (   ) Other

Have you ever experience any other severe injury or accident before?

(   ) Yes, When? ________________________________   (   ) No

Any other Question or comment?

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Thank you for choosing Richard Kim Chiropractic P.C.