CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____

City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birthdate_____ SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?_____

_____

2 INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr._____ 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X_____

Responsible Party Signature

_____ _____

Relationship Date

3 PHONE NUMBERS

Home_____ Work_____ Ext____

Cell Phone _____ E-mail_____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Home Phone_____ Work Phone_____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date_____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)_____

5 PATIENT CONDITION

Please Describe Your Complaint: _____

_____

_____

a. Description:

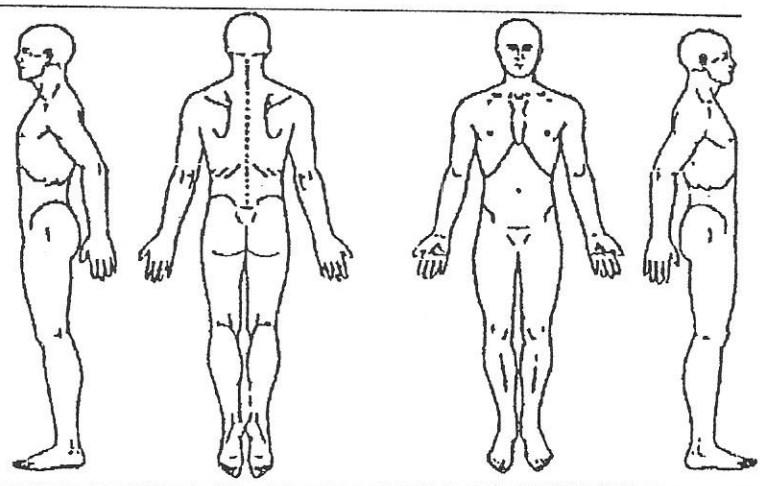
☐ Sharp Pain ☐ Numb
☐ Dull Pain ☐ Shooting
☐ Ache ☐ Gripping
☐ Weak ☐ Burning
☐ Throbbing ☐ Tingling
☐ Cramps ☐ Stiffness
☐ Other _____

_____

b. Frequency (% during day):

☐ Constant (76-100%)
☐ Frequent (51-75%)
☐ Occasional (26-50%)
☐ Intermittent (25% or less)

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



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5 PATIENT CONDITION CONTINUED

Indicate intensity of your pain at its lowest and highest level No Pain [0] [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] Unbearable Pain

Your symptoms are ☐ decreasing ☐ not changing ☐ increasing

Symptoms are worse in the ☐ Morning ☐ Afternoon ☐ Night ☐ Increases during the day ☐ Same all day.

When did your problem begin: SPECIFIC DATE IF POSSIBLE?_____ Describe how your problem began:_____

_____

_____

Have you been treated *for this episode?* ☐ Yes ☐ No

If yes, by whom? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other _____

Are you currently being seen? ☐ Yes ☐ No

When and what treatment? ____/____/____ _____

_____

In the past have you been treated for the same or a similar problem? ☐ Yes ☐ No

If yes, who did you see for that episode? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other _____

When and what treatment did you receive? _____

_____

What makes your problem better? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity

What makes your problem worse? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity

How would you rate your general stress level? ☐ Little or No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed

General Physical Activity: ☐ No regular exercise program ☐ Light exercise program ☐ Moderate exercise program ☐ Strenuous exercise program

Are your complaints affecting your ability to be active?

☐ No effect
☐ Some physical restrictions (able to perform light duty work and household tasks)
☐ Need limited assistance with common everyday tasks.
☐ Need assistance often.
☐ Have a significant inability to function without assistance.
☐ Am totally disabled (impaired). Cannot care for self.

Physical activity at work: ☐ Sitting more than 50% of workday ☐ Light manual labor ☐ Manual labor ☐ Heavy manual labor ☐ Repeated motion

Occupation: _____ ☐ FT ☐ PT Has your work status changed because of this complaint? ☐ YES ☐ NO

What is your current work status?

[1] Full time, no restrictions.
[2] Full time, with restrictions.
[3] Part time, no restrictions.
[4] Part time, with restrictions.
[5] Off work due to restrictions.
[6] Full time homemaker.
[7] Unemployed.
[8] Retired.
[9] Full time student.
[10] Other:_____

6 MEDICATIONS | ALLERGIES | VITAMINS/HERBS/MINERALS

_____ _____ _____

_____ _____ _____

Pharmacy Name_____ _____ _____

Pharmacy Phone _____ _____ _____

Patient's signature: _____ **Date:** ____/____/____

Doctor's Additional Comments/General Health Concerns:

_____

_____

_____

_____

_____

HEALTH HISTORY

If you have ever had a listed condition in the past, please check it in the Past column. If you are presently troubled by a particular condition, check it in the Present column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

PATIENT HEALTH QUESTIONNAIRE

Past	Present	
☐	☐	Neck Pain (723.1)
☐	☐	Shoulder Pain (719.41)
☐	☐	Pain in Upper Arm or Elbow (719.42)
☐	☐	Hand Pain (719.44)
☐	☐	Wrist Pain (719.43)
☐	☐	Upper Back Pain (724.1)
☐	☐	Low Back Pain (724.2)
☐	☐	Pain in Upper Leg or Hip (719.45)
☐	☐	Pain in Lower Leg or Knee (729.5)
☐	☐	Pain in Ankle or Foot (719.47)
☐	☐	Jaw Pain (526.9)
☐	☐	Swelling/Stiffness of Joint(s)
☐	☐	Fainting (780.2)
☐	☐	Visual Disturbances (368.9)
☐	☐	Convulsions (780.3)
☐	☐	Dizziness (780.4)
☐	☐	Headache (784.0)
☐	☐	Muscular Incoordination (781.3)
☐	☐	Tinnitus (Ear Noises) (388.30)
☐	☐	Rapid Heart Beat (785.0)
☐	☐	Chest Pains (786.50)
☐	☐	Loss of Appetite (783.0)
☐	☐	Anorexia (307.1)
☐	☐	Abnormal Weight ☐ Gain (783.1) ☐ Loss (783.2)
☐	☐	Excessive Thirst (783.5)
☐	☐	Chronic Cough (786.2)
☐	☐	Chronic Sinusitis (473.9)
☐	☐	General Fatigue (780.7)
☐	☐	Irregular Menstrual Flow (626.4)
☐	☐	Profuse Menstrual Flow (626.7)
☐	☐	Breast Soreness/Lumps (611.72)
☐	☐	Endometriosis (617.9)
☐	☐	PMS (625.4)
☐	☐	Loss of Bladder Control (788.30)
☐	☐	Painful Urination (788.1)
☐	☐	Frequent Urination (788.41)
☐	☐	Abdominal Pain (789.0)
☐	☐	Constipation/irregular bowel habits (564.0)
☐	☐	Difficulty in Swallowing (787.2)
☐	☐	Heartburn/Indigestion (787.1)
☐	☐	Dermatitis/Eczema/Rash (692.9)
☐	☐	Depression (311)

Past	Present	
☐	☐	Aortic Aneurysm (441.5)
☐	☐	High Blood Pressure (401.9)
☐	☐	Angina (413.9)
☐	☐	Heart Attack (410.9)
☐	☐	Stroke (436)
☐	☐	Asthma (493.9)
☐	☐	Cancer (199.1)
☐	☐	Tumor (229.9)
☐	☐	Prostate Problems (601.9)
☐	☐	Blood Disorder (790.6)
☐	☐	Emphysema (chronic lung disorders) (492.8)
☐	☐	Arthritis (716.9)
☐	☐	Rheumatoid Arthritis (714.0)
☐	☐	Diabetes (250.0)
☐	☐	Epilepsy (349.5)
☐	☐	Ulcer (556.9)
☐	☐	Liver (573.9) / Gallbladder (575.9) problems
☐	☐	Kidney Stones (592.0)
☐	☐	Hepatitis (573.3)
☐	☐	Bladder Infection (595.9)
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis (558.9)
☐	☐	Irritable Colon (564.1)
☐	☐	HIV/AIDS (042)
☐	☐	Systemic Lupus
☐	☐	Other_____

If a family member has had any of the following please mark the appropriate box:

☐ Cancer
☐ Rheumatoid Arthritis
☐ Diabetes
☐ Heart Problems
☐ Lung Problems
☐ High Blood Pressure
☐ Epilepsy
☐ Chronic Back Problems
☐ Chronic Headaches
☐ Lupus
☐ Other Conditions _____
☐ _____

Yes	No	
☐	☐	Do you have a permanent disability rating?
☐	☐	Location_____
☐	☐	Date rating received ____/____/____
		Rating Percentage _____%

Please check any of the following that apply to you.

Past	Present	
☐	☐	Pregnancy (V22.2)
☐	☐	Birth Control Pills
☐	☐	Hormonal/Estrogen Replacement
☐	☐	Medications (list if not listed elsewhere)
		_____
		_____
☐	☐	Hospitalization/Surgical Procedures (list if not described elsewhere) _____
		_____

Past	Present	
☐	☐	Tobacco (305.1)
☐	☐	Alcohol (305.0)
☐	☐	Drug or Alcohol Dependence (303.9)
☐	☐	Coffee/Tea/Caffeinated Soft drinks: cups/cans per day_____
		_____

Present: Weight _____ pounds **Height** ____feet ____inches

Patient's Signature: _____ **Date:**____/____/____