

WELCOME TO



As a prospective new patient...

We thank you for providing us the opportunity to serve you in our professional and courteous manner.

We hope your experience while at our office is comfortable and gratifying.

Your comments will always be welcomed.

REGISTRATION

Date _____

Home Phone _____

Patient _____
Last Name First Name Initial

Street Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Social Security # _____ Driver's License # _____

Insured's Name _____
Last Name First Name Initial

Relationship To Insured Self Spouse Child Other Condition Related to Illness Employment Auto Other

EMPLOYER	Company Name _____ Occupation _____ Address _____ Phone _____ City _____ State _____ Zip _____		
SPOUSE	Name _____ <small style="margin-left: 100px;">Last Name</small> <small style="margin-left: 200px;">First Name</small> <small style="margin-left: 100px;">Initial</small> Birthdate _____ Social Security # _____ Employer Name _____ Occupation _____ Address _____ Phone _____ City _____ State _____ Zip _____		
PATIENT INSURANCE INFORMATION	Please <input checked="" type="checkbox"/> any and all insurance coverage you or your spouse has applicable in this case. <input type="checkbox"/> MEDICARE <input type="checkbox"/> BLUE SHIELD <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> MEDICAID <input type="checkbox"/> MAJOR MEDICAL <input type="checkbox"/> UNION PLAN <input type="checkbox"/> BLUE CROSS <input type="checkbox"/> WORKER'S COMPENSATION <input type="checkbox"/> OTHER BCBS I.D. # _____ MEDICARE/MEDICAID I.D. # _____ MAJOR MEDICAL OR AUTO INSURANCE Date of accident _____ Insurance Company Name _____ Adjuster _____ Address/Phone _____ Claim # _____ Policy # _____ Effective Date _____		
SPOUSE CO-INSURANCE INFORMATION	MAJOR MEDICAL ONLY Insurance Company Name _____ Address/Phone _____ Policy # _____ Effective Date _____		
MEDICAL AND LEGAL INFORMATION	<table style="width: 100%; border: none;"> <tr> <td style="width: 70%; border: none;"> Referred by _____ Present Complaint _____ Known Medical Problems _____ </td> <td style="width: 30%; border: none; vertical-align: top;"> Attorney _____ Address _____ Phone _____ </td> </tr> </table> Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No Family Physician _____ Person to contact in emergency (Name and Phone #) _____	Referred by _____ Present Complaint _____ Known Medical Problems _____	Attorney _____ Address _____ Phone _____
Referred by _____ Present Complaint _____ Known Medical Problems _____	Attorney _____ Address _____ Phone _____		
PATIENT AGREEMENT	ASSIGNMENT AND RELEASE I, the undersigned, have insurance coverage with _____ <small style="margin-left: 400px;">Name of Insurance Company</small> and assign directly to Dr. _____ all medical 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 my insurance submissions. _____ <small style="margin-left: 200px;">Signature of Insured/Guardian</small> <small style="margin-left: 200px;">Date</small>		

CHIROPRACTIC HEALTH QUESTIONNAIRE

Date _____

Patient name _____ Birthdate _____

Reason for visit _____

Have you been treated before for this problem? No Yes

If yes, by Physician Doctor of Chiropractic Physical Therapist Osteopath Other _____

What did they do and/or recommend? _____

When did your symptoms appear? _____ Is this condition getting progressively worse? Yes No Unknown

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 Walking Bending Lying down

Other _____

Your Occupation _____

(Describe activities – sitting, lifting, etc.)

Have you ever had chiropractic care for other problems? No Yes When? _____

Do you take Muscle relaxers Pain killers Insulin Birth control pills Over-the-counter meds

Other prescription drugs _____ Please list all medication in the space at bottom of page.

Date of last: Physical exam _____ Spinal x-ray _____ Blood test _____

Spinal exam _____ Chest x-ray _____ Urine test _____

Dental x-ray _____ MRI, CT-scan, bone scan _____

Sleep _____ hrs/night Do you sleep on your Back Side Stomach Non-job exercise _____ hrs/wk

Age of mattress _____ or waterbed _____ Is your bed comfortable? No Yes

What kind of pillow do you use? Thick Medium Thin None Support

Do you wear Heel lifts Shoe lifts Arch supports Orthotics, describe _____

CONDITIONS Check (✓) conditions you have or have had in the past.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Fractures | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tumors, growths |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hernia | <input type="checkbox"/> Polio | <input type="checkbox"/> Vaginal infections |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Prostate problem | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatoid arthritis | |

MEDICATIONS List medications you are currently taking

VITAMINS/HERBS/MINERALS

Allergies _____	
Pharmacy Name _____ Phone _____	

GENERAL SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

<p>GENERAL</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Chills <input type="checkbox"/> Dental problems <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats <input type="checkbox"/> Tiredness <input type="checkbox"/> Weight gain	<p>GASTROINTESTINAL</p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p>EYE, EAR, NOSE, THROAT</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - flashes <input type="checkbox"/> Vision - halos	<p>MEN only</p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other	
<p>GENITO-URINARY</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination	<p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p>SKIN</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p>WOMEN only</p> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other	
			Date of last menstrual period _____ Date of last Pap Smear _____ Have you had a mammogram? _____ Are you pregnant? _____ Number of children _____	

NECK, BACK, EXTREMITIES Check (✓) symptoms you currently have or have had in the past year.

<p>NECK</p> <input type="checkbox"/> Pain in neck <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Neck weakness <input type="checkbox"/> Pinched nerve in neck <input type="checkbox"/> Neck feels out of place <input type="checkbox"/> Muscle spasms in neck <input type="checkbox"/> Grinding/popping sounds in neck	<p>SHOULDERS</p> <table border="0"> <tr> <td></td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Left</td> </tr> <tr> <td><input type="checkbox"/> Pain in shoulder joint</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain across shoulders</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Can't raise arm</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Above shoulder level</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Over head</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Tension in shoulders</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Pinched nerve in shoulder</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> </table> <p>MID-BACK</p> <input type="checkbox"/> Mid-back pain <input type="checkbox"/> Mid-back stiffness <input type="checkbox"/> Pain between shoulder blades		Right	Left	<input type="checkbox"/> Pain in shoulder joint	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Pain across shoulders			<input type="checkbox"/> Can't raise arm	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Above shoulder level			<input type="checkbox"/> Over head			<input type="checkbox"/> Tension in shoulders			<input type="checkbox"/> Pinched nerve in shoulder	<input type="checkbox"/> R	<input type="checkbox"/> L	<p><input type="checkbox"/> Pain from front to back <input type="checkbox"/> Muscle spasms in mid-back</p> <p>ARMS & HANDS</p> <table border="0"> <tr> <td></td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Left</td> </tr> <tr> <td><input type="checkbox"/> Pain in upper arm</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in elbow</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in forearm</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in hand</td> <td style="text-align: center;"><input type="checkbox"/> R</td> 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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/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature

Date

Reviewed by _____

Doctor

Date