



Chiropractic Registration and History

Personal and Family Health History

Name _____
 Date _____
 Address _____
 City _____ State ____ Zip _____
 Phone: (H) _____
 (Cell) _____
 E-mail _____
 Date of Birth _____ Age _____
 Sex Male Female
 If Female, are you currently pregnant? Yes No
 Family Doctor _____

Referred By _____
 Occupation _____
 Employer _____
 Marital Status S M D W
 Spouse's Name _____
 Spouse's Occupation _____
 In case of Emergency, Contact
 Name _____
 Relationship _____
 Phone: (W) _____
 (Cell) _____

Number of Children, Ages, and Previous Chiropractic Care?

Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____

How many times have you visited a chiropractor in your lifetime? _____ Never

Auto and work- related injuries can cause serious spinal problems. Is this visit related to an accident or injury? Yes No Date of Incident _____

Insurance:

Who is responsible for this account? _____
 Relationship to Patient _____
 Insurance Company _____
 Group # _____ ID # _____
 Is patient covered by additional Insurance: Y N
 Subscriber's Name _____
 Birth date _____
 Relationship to Patient _____
 Insurance Company _____
 Group # _____ ID # _____

Assignment and Release:

I certify that I, and/or my dependent(s), 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 authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

 Signature of Patient, Parent, Guardian or Personal Representative

 Date

 Please print name of Patient, Parent, Guardian or Personal Representative

 Relationship to Patient

Current Health Habits

- | | |
|--|--------------------------------------|
| Exercise | Work Activity |
| <input type="checkbox"/> None | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Moderate | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Daily | <input type="checkbox"/> Light Labor |
| <input type="checkbox"/> Heavy | <input type="checkbox"/> Heavy Labor |
| Habits | Packs/day _____ |
| <input type="checkbox"/> Smoking | Drinks/Week _____ |
| <input type="checkbox"/> Alcohol | Cups/Day _____ |
| <input type="checkbox"/> Coffee/ Caffeine Drinks | Reason _____ |
| <input type="checkbox"/> High Stress Level | |

Current Health Condition

1. Present Complaint (be brief) Reason For Your Visit Today _____
- Pain or Problem started on _____
- Pains are: (select all that apply)
- | | | |
|-----------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull/Ache | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Constant | <input type="checkbox"/> Intermittent | <input type="checkbox"/> Occasional |
| <input type="checkbox"/> Daily | <input type="checkbox"/> _____ times per Week/Month | |
- What activities aggravate your condition/pain? _____
- What activities lessen your condition/pain? _____
- Is condition worse during certain times of the day? _____
- Does this condition interfering with your
- | | | |
|-------------------------------------|--------------------------------------|-------------------------------|
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Routine | <input type="checkbox"/> Work |
| <input type="checkbox"/> Recreation | <input type="checkbox"/> Other _____ | |
- Is this condition:
- | | |
|--|---|
| <input type="checkbox"/> getting progressively worse | <input type="checkbox"/> staying the same |
| <input type="checkbox"/> getting better | <input type="checkbox"/> Not sure |
- Other Doctors seen for this condition _____
- Any home remedies? _____

Other symptoms:

- | | |
|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins & Needles in Arms |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness in Fingers |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Numbness in Toes |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Light Bothers Eyes |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ears Ring |
| <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Cold Sweats |
| | <input type="checkbox"/> Loss of Smell |

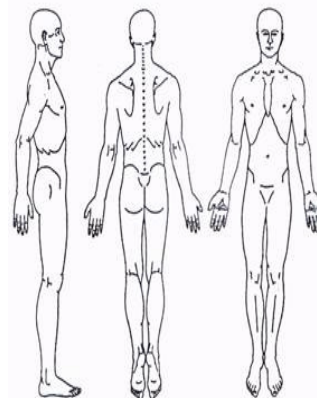
Is there a family history of:

- | | | | |
|---------------|--------------------------|--------------------------|--------------------------|
| | Heart Disease | Arthritis | Cancer |
| Father's Side | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mother's Side | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- Injuries, Surgeries, & Medications you have had
- | | |
|--------------------|-------|
| | Date |
| Falls _____ | _____ |
| Head Injures _____ | _____ |
| Broken Bones _____ | _____ |
| Dislocation _____ | _____ |
| Surgeries _____ | _____ |
| Medications _____ | _____ |

2. Second Complaint (be brief) Reason For Your Visit Today _____
- Pain or Problem started on _____
- Pains are:
- | | | |
|-----------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull/Ache | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Constant | <input type="checkbox"/> Intermittent | <input type="checkbox"/> Occasional |
| <input type="checkbox"/> Daily | <input type="checkbox"/> _____ times per Week/Month | |
- What activities aggravate your condition/pain? _____
- What activities lessen your condition/pain? _____
- Is condition worse during certain times of the day? _____
- Does this condition interfering with your
- | | | |
|-------------------------------------|--------------------------------------|-------------------------------|
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Routine | <input type="checkbox"/> Work |
| <input type="checkbox"/> Recreation | <input type="checkbox"/> Other _____ | |
- Is this condition:
- | | |
|--|---|
| <input type="checkbox"/> getting progressively worse | <input type="checkbox"/> staying the same |
| <input type="checkbox"/> getting better | <input type="checkbox"/> Not sure |
- Other Doctors seen for this condition _____
- Any home remedies? _____

- | |
|--|
| <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Buzzing in Ear |



- | | |
|--------------------------|--------------------------|
| Diabetes | Other |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |