CHIROPRACTIC REGISTRATION AND HISTORY

1 Patient Information

Date Of Appointment____________________

FIRST NAME________________________________ LAST NAME______________________________ MI________

Address_______________________________ City________________________ St.____________ Zip_________

E-mail____ Work #____

Birthdate ________________ Age _______ Male Female SSN _________________________________

Married Single Widowed Minor Height ____________ weight_____________

Your Occupation___________________________ Employer Name_______________________________________

Employer Address_______________________________________ City_________________ St.__________ Zip____________

Name of Spouse / Guardian ____________________ Who were you referred by? ____________________________

List Any Chronic illnesses

2 Phone Numbers

Cell Phone ____________ Home Phone ____________

Best time to reach you? __________

In case of emergency Contact:

Name________________________________

Relation______________________________

Home # ________________ Work # _______________

3 Accident Information

Is condition due to accident? Yes No
If yes, Date____________________

Type of accident Auto Work Other

Have you ever experienced these symptoms while working? Yes No If Yes:

Explain:

4 Patient Condition

What Are Your Syptoms?

When did your symptoms appear? ______________________ Is the condition getting worse? Yes No Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ______________________

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling

Cramps Stiffness Swelling Other ________________________________

How often do you have this pain? _____________________ Is it constant or does it come and go? ___________________

Does your pain interfere with your: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Lying Down Standing Walking Bending

5 Insurance Information

WHO IS RESPONSIBLE FOR THIS ACCOUNT? ____________________

RELATIONSHIP TO PATIENT ____________________

INSURANCE CO. ____________________

MEMBER ID # ____________________ GROUP # ____________________

Is patient covered by additional Insurance? YES NO If yes, please fill out below:

Subscribers Name ____________________ Subscribers Birthdate ____________________

Relationship to patient

INSURANCE CO. ____________________

MEMBER ID # ____________________ GROUP # ____________________

6 Health Information

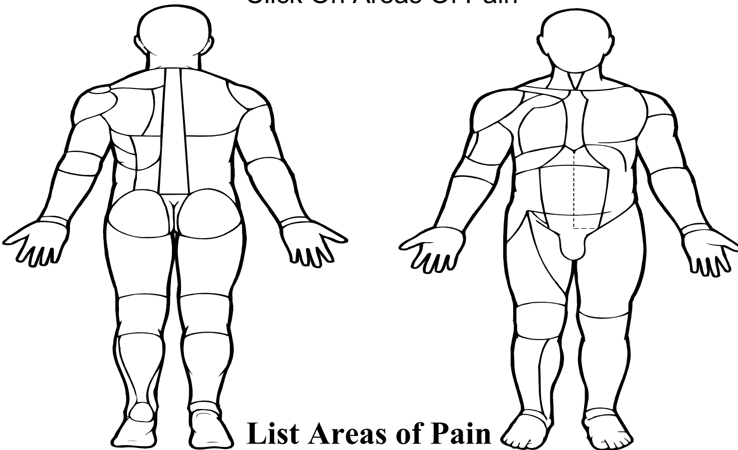
What treatment have you already received for your condition?

Are you pregnant? Yes No Due date ____________

INJURIES (In Past 5 years)

SURGERIES (In Past 5 Years)

Click On Areas Of Pain



List Areas of Pain

7 Exercise

Level of Exercise

Number of Days Per Week ____________

Number of Hours Per Week ____________

Type of Activity

8 Work Activity

Job Description:

Hours of Sitting at work per day ____________

9 Habits

SMOKING PACKS/DAY ____________

ALCOHOL DRINKS/PER WEEK ____________

CAFFEINE DRINKS CUPS/DAY ____________

HIGH STRESS LEVEL

REASON:

Method of Payment

Cash Check Credit Card Other

All first visit charges are payable when services are rendered.

Signature ____________________ **Name** ____________________ **Date** ____________________