PATIENT REGISTRATION AND HISTORY

PATIENT INFORMATION

Name _____Date _____

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____

Patient SS# _____Driver Lic. # _____

Occupation _____

Employer or School Name_____

Address _____City _____

Hobbies _____

☐ Single ☐ Married ☐ Widowed ☐Separated ☐ Divorced

Spouse (or Parent) Name _____

Birthdate _____ Occupation _____

Employer _____Work # _____

Child Name _____ Birthdate _____

Child Name _____ Birthdate _____

Child Name _____ Birthdate _____

Child Name _____ Birthdate _____

Who may we thank (M.D., friend, etc.) for referring you?

_____

CURRENT CONDITION

☐Headache ☐Neck pain ☐Midback pain ☐Lowback pain ☐Other

Describe the reason for today's visit: _____

_____

Symptom frequency? ☐0-25% ☐26-50% ☐51-75% ☐76-100%

Symptoms last? ☐All day ☐Hours ☐Minutes ☐Disturb sleep

Describe how this limits your daily activities: _____

_____

When did this begin? _____

What caused it? _____

From 0 to 100% how much do you expect to recover? _____

List <u>other</u> problems: ☐Heart/ Stroke/ HBP ☐Cancer ☐Diabetes

_____

Please list other concerns you wish to discuss with the doctor:

_____

INSURANCE INFORMATION

Insurance company name? _____

Policy holder name? _____ Relationship _____

Policy/Group# _____ ID# _____

List other health insurance: _____

☐ Copy of current insurance card and driver's license for the file.

PHONE NUMBERS

Home # _____ Mobile # _____

Work # _____ Ext. _____

Email: _____

Where can we call you during the day? _____

Best time and place to call you? _____

EMERGENCY CONTACT (list a relative <u>not</u> living with you)

Name _____ Relationship_____

Home # _____ City _____State __

ACCIDENT INFORMATION

Is condition due to an accident? ☐ No ☐ Yes Date _____

Type of accident? ☐Work* ☐Auto* ☐Home ☐Other _____

****IF YES, PLEASE ASK FOR A WORK OR AUTO ACCIDENT FORM.***

To whom have you reported your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other _____

Attorney Name (if applicable) _____

Office Name _____ City _____

Phone # _____ Fax # _____

LIVING ACTIVITIES

EXERCISE

☐ None ☐ Moderate ☐ Heavy ☐ Daily ☐ Weekly _____ times

WORK TASKS

☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ _____

LIFESTYLE HABITS

☐ **Tobacco** - Packs/Day _____ other _____ Total Years ____

☐ **Alcohol** - Drinks/Week _____ ☐ **Coffee**/cola - Cups/Day _____

Diet: ☐ Vegetarian ☐ Good ☐ Fair ☐ Poor ☐ On diet _____

Water - Cups/Day _____ ☐ **High Stress** - Reason _____

PATIENT REGISTRATION AND HISTORY

MEDICAL/ SURGICAL HISTORY

Are you pregnant? □ No □ Yes Due Date _____ Number of previous pregnancies _____ natural births _____ cesareans _____

If you have had the following, please list: *the approximate date*, *what occurred*, *care received* and *any persistent problems*.

Auto Accident: □never □past year □past 5 yrs □over 5 yrs

Sport/Other Personal Injury, Slip/Fall, Broken Bone, Dislocation, Head Injury: □never □past year □past 5 yrs □over 5 yrs

Year _____ Incident _____ Care/Problems _____

Year _____ Incident _____ Care/Problems _____

List any Hospitalization, Surgery, Major Illness, etc… (Include implants & prostheses: pacemakers, pumps, joints, etc…)

Year _____ Incident _____ Care/Problems _____

Year _____ Incident _____ Care/Problems _____

HEALTH CARE HISTORY

List healthcare providers that you have seen during the past few years (particularly those related to your current problem).

Chiropractic Doctor: □ never □ not for this Last visit _____ City _____ Name_____

Medical Doctor: □ none Last visit _____ Purpose _____ Results/Follow-Up _____

Name_____ MD/DO City _____ Phone _____ Fax _____

List things that you have tried for your current problem (acupuncture, massage, nutrition, physical therapy, medication, etc).

What _____ Care/Results _____

What _____ Care/Results _____

List recent (2 yrs) medical tests (X-ray, MRI, Bone scan, CT scan, NCV, blood work, etc.) and notable results that you had.

What _____ Results _____

What _____ Results _____

What _____ Results _____

MEDICATIONS/ DRUGS

Name _____ Purpose _____

Name _____ Purpose _____

Name _____ Purpose _____

Name _____ Purpose _____

Name _____ Purpose _____

ALLERGIES

Food/ Drug _____

_____

Environmental/ Seasonal ____

_____

Other _____

HEALTH SUPPLEMENTS

Vitamins _____

_____

Herbs _____

Other _____

Would you like supplement information? □Yes □No

FAMILY HEALTH HISTORY

List family members who have health problems or a condition like yours. **□Heart/stroke □Blood pressure □Diabetes □Cancer □Other**

_____

AUTHORIZATION, ASSIGNMENT, RELEASE & PRIVACY: By signing below, I verify that I have read this page and certify that the information is complete and correct to the best of my knowledge. I will not hold the doctor or his staff responsible for any errors or omissions that I may have made in the completion of this form. I will notify this office of changes in health status, insurance or other information. I authorize and assign payment of my insurance benefits directly to this chiropractor and chiropractic office. I authorize the doctor to release all information necessary to communicate with physicians and other healthcare providers and payers to secure the payment of benefits. I understand and agree that regardless of insurance coverage, I am personally responsible for all costs of the care rendered. I authorize treatment for the patient listed above and agree to allow use of related Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. Changes to this agreement must be made in writing.

Patient/Guardian Signature: _____ Date: _____