PATIENT REGISTRATION Today's Date________________________

Please complete all fields of the form. Indicate N/A for questions that do not apply. Thank you.

Patient:____Birth Date:___________________________

Address:____________________________________City:___________________State:________Zip:___________

Home PH:_________________________Cell PH:_________________________Email:______________________________

Occupation:__________________________________Employer:____

Name of Spouse:____ # of Children___________________________

How did you learn of this office?____

Who is responsible for payment? ☐ Self ☐ Spouse ☐ Parent ☐ Other____________________________________

Insurance Company(s):____

Insured Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other___________________________________

Insured Name:____ Birth Date__________________________________

Purpose of this appointment and list your complaint(s):____

____

Date injury occurred or condition started: ____

How did injury/condition occur? ☐ Auto ☐ On the Job Other ____

What makes your condition feel **Better?** ____

____

What makes your condition feel **Worse?**____

____

Other Doctors seen for this condition:____

Have you been treated for any health condition in the last year? ☐ No ☐ Yes, Explain:__________________________

X-RAYS FROM THIS OFFICE ARE SENT TO BE READ BY AN X-RAY RADIOLOGIST:

I understand that in the event x-rays are taken, that the services of a qualified radiologist from *Diagnostic Imaging Inc.* will be utilized for a second opinion or further interpret my x-rays and give consent for their release. I understand that there will be a **$25 fee for this service which is separate from that of the chiropractic clinic.**

PROFESSIONAL SERVICES CONSENT, RELEASE OF INFORMATION & INSURANCE INFORMATION:

I authorize the assignment of insurance benefits to the chiropractor or chiropractic office. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. I understand I may receive a billing statement for: insurance denial, professional fees that have been applied to my deductible, co-payments, or any balance due stated by my insurance company as my responsibility. In the event that I receive payment for any services I agree to promptly remit payment to the chiropractor or chiropractic office. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless other arrangements were made in writing. I understand I am responsible for collections fees, court costs and reasonable attorney fees to collect unpaid accounts.

I herby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examinations, x-ray studies, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my patient health record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to the family member or employer of the patient for all or part of the clinic's charges, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare fund, or the patient's employer.

Patient /Guardian Signature____

HEALTH QUESTIONNAIRE

Patient____Date____

PLEASE MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING.

Musculoskeletal System
- ☐ Low back pain/stiffness
- ☐ Mid back pain/stiffness
- ☐ Pain between shoulders
- ☐ Neck pain/stiffness
- ☐ Arm/wrist/elbow problems
- ☐ Shoulder problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Muscle spasms
- ☐ Loss of motion/movement
- ☐ Chest pain

Eye & Ear
- ☐ Eye infection / inflammation
- ☐ Vision problems
- ☐ Ear pain / discharge
- ☐ Hearing loss/noises

Genitourinary System
- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

Female ONLY
- ☐ Hormonal problems
- ☐ Breast problems
- ☐ Reproductive problems

Are you PREGNANT ?
☐ **YES** ☐ **NO**

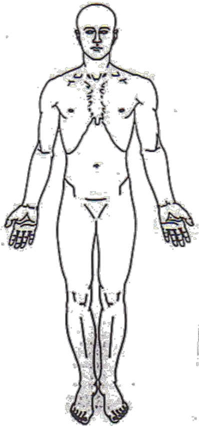
Habits
- ☐ Cigarettes________pk/day
- ☐ Coffee or tea _____#cups/day
- ☐ Soda __________#/day
- ☐ Drug abuse
- ☐ Alcohol abuse

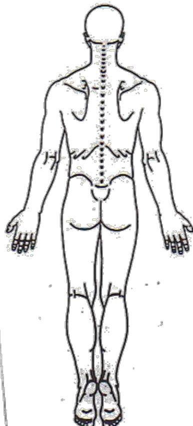
Gastrointestinal System
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver problems
- ☐ Gallbladder problems
- ☐ Weight trouble/changes

Nose & Throat
- ☐ Nose pain/bleed/discharge
- ☐ Mouth/throat sore/hoarse
- ☐ Jaw / mouth problems
- ☐ Sinus problems

Nervous System
- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscle jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

Cardiovascular & Respiratory
- ☐ Chest / heart pain
- ☐ Varicose veins
- ☐ Heart problems
- ☐ Hard to breathe
- ☐ Lung problems





Circle area(s) of complaint.

Mark "X" on pain scale below.

Family History: **M = me** **F = family**
- ☐ Arthritis
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Epilepsy
- ☐ Heart Attack
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Concussion
- ☐ Asthma

☐ None Apply

Rate pain: |____|
None **Unbearable Pain**

Allergies: ☐ None ____

Medications: ☐ None ____

____

Over-the-Counter Medications (OTC) & Vitamins: ☐ None ____

____

List All Surgeries or Hospitalizations: ☐ None ____

____

Prior Illness or Injuries (Auto, Work, Etc.): ☐ None ____

____

Other health conditions you presently suffer from: ☐ None ____

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