

# CHIROPRACTIC REGISTRATION INFORMATION

# 1

## PATIENT INFORMATION

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City State ZIP

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Carrier: \_\_\_\_\_

Email: \_\_\_\_\_

Sex:  M  F     Age    Birthdate: \_\_\_\_\_

Single     Married     Widowed

Separated     Divorced

In case of emergency, contact: \_\_\_\_\_

\_\_\_\_\_ Name

Relationship Phone

\_\_\_\_\_

Address City State

Social Security #: \_\_\_\_\_

Driver's License #: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

**Whom may we thank for referring you?:** \_\_\_\_\_

\_\_\_\_\_

# 2

## INSURANCE

Person responsible for payment: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Are you insured?  Yes  No

Health insurance name: \_\_\_\_\_

Insurance Co's Phone: \_\_\_\_\_

Insurance Co's Address: \_\_\_\_\_

\_\_\_\_\_

Policy holder's name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Group #: \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Company name: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

SS#: \_\_\_\_\_

Group #: \_\_\_\_\_

# 3

## ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No

Type of accident:  Auto  Work  Other: \_\_\_\_\_

To whom have you reported it?

Auto Ins.  Employer  Other: \_\_\_\_\_

Attorney (If applicable): \_\_\_\_\_

# 4

## PAYMENT IS EXPECTED AT THE TIME OF VISIT

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that our 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 our office will be credited upon receipt, however, I clearly understand and agree that any 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 services rendered me will be immediately due and payable.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# PATIENT INTAKE FORM

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Is today's problem cause by:  Auto Accident  Workman's Compensation  Other: \_\_\_\_\_

2. What is your main complaint? \_\_\_\_\_

3. Indicate on the drawings to the right where you have pain/symptoms →

5. How do you think your problem began? \_\_\_\_\_

6. How often do you experience your symptoms?

- Constantly (76-100% of the time)       Occasionally (26-50% of the time)  
 Frequently (51-75% of the time)       Intermittently (1-25% of the time)

7. How would you describe the type of pain?

- Sharp       Dull       Diffuse       Achy  
 Burning       Shooting       Stiff       Numb  
 Tingly       Sharp with motion       Shooting with motion       Electric-like with motion  
 Other: \_\_\_\_\_

8. How are your symptoms changing with time?

- Getting Worse       Staying the Same       Getting Better

9. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

1    2    3    4    5    6    7    8    9    10    (please circle)

10. How much has the problem interfered with your work?

- Not at all       A little bit       Moderately       Quite a bit       Extremely

11. How much has the problem interfered with your social activities?

- Not at all       A little bit       Moderately       Quite a bit       Extremely

12. Who else have you seen for your problem?

- Chiropractor       Neurologist       Primary Care Physician  
 ER Physician       Orthopedist       No one  
 Massage Therapist       Physical Therapist       Other: \_\_\_\_\_

13. Who is your primary care physician? \_\_\_\_\_

14. Have you had any spinal x-rays, MRI, CT Scan?  No  Yes Dates taken: \_\_\_\_\_

15. How long have you had this problem? \_\_\_\_\_

16. Do you consider this problem to be severe?

- Yes       Yes, at times       No

17. What aggravates your problem? \_\_\_\_\_

18. What alleviates your problem? \_\_\_\_\_

19. What concerns you the most about your problem; what does it prevent you from doing? \_\_\_\_\_

21 How would you rate your overall health?

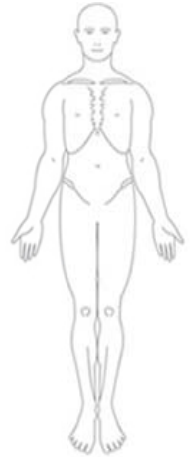
- Excellent       Very Good       Good       Poor

22. What type of exercise do you do?

- Strenuous       Moderate       Light       None

23. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis       Diabetes       Lupus  
 Heart Problems       Cancer       ALS



24. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have the condition listed below, place a check in the "present" column.

<b>Past Present</b>	<b>Past Present</b>	<b>Past Present</b>
<input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/> Neck Pain	<input type="checkbox"/> <input type="checkbox"/> Heart Attack	<input type="checkbox"/> <input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> <input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> <input type="checkbox"/> Chest Pain	<input type="checkbox"/> <input type="checkbox"/> Frequent Urination
<input type="checkbox"/> <input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/> <input type="checkbox"/> Low Back Pain	<input type="checkbox"/> <input type="checkbox"/> Angina	<input type="checkbox"/> <input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/> <input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> <input type="checkbox"/> Kidney Stones	<input type="checkbox"/> <input type="checkbox"/> Allergies
<input type="checkbox"/> <input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/> <input type="checkbox"/> Kidney Disorders	<input type="checkbox"/> <input type="checkbox"/> Depression
<input type="checkbox"/> <input type="checkbox"/> Wrist Pain	<input type="checkbox"/> <input type="checkbox"/> Bladder Infection	<input type="checkbox"/> <input type="checkbox"/> Systemic Lupus
<input type="checkbox"/> <input type="checkbox"/> Hand Pain	<input type="checkbox"/> <input type="checkbox"/> Painful Urination	<input type="checkbox"/> <input type="checkbox"/> Epilepsy
<input type="checkbox"/> <input type="checkbox"/> Hip Pain	<input type="checkbox"/> <input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/> <input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/> <input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/> <input type="checkbox"/> Prostate Problems	<input type="checkbox"/> <input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> <input type="checkbox"/> Knee Pain	<input type="checkbox"/> <input type="checkbox"/> Abnormal Weight Gain/Loss	
<input type="checkbox"/> <input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/> <input type="checkbox"/> Loss of Appetite	<b>For Females Only</b>
<input type="checkbox"/> <input type="checkbox"/> Jaw Pain	<input type="checkbox"/> <input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> <input type="checkbox"/> Birth Control Pills
<input type="checkbox"/> <input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/> <input type="checkbox"/> Ulcer	<input type="checkbox"/> <input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Pregnancy
<input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> <input type="checkbox"/> Liver/Gall Bladder Disorder	
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> General Fatigue	
<input type="checkbox"/> <input type="checkbox"/> Tumor	<input type="checkbox"/> <input type="checkbox"/> Muscular Incoordination	
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Visual Disturbances	
<input type="checkbox"/> <input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> <input type="checkbox"/> Dizziness	
<input type="checkbox"/> <input type="checkbox"/> Other: _____		

25. List all prescription medications you are currently taking: \_\_\_\_\_

26. List all of the over-the-counter medications you are currently taking: \_\_\_\_\_

27. List all surgical procedures you have had: \_\_\_\_\_

28. What activities do you do outside work? \_\_\_\_\_

29. Have you ever been hospitalized?  No  Yes  
If yes, why: \_\_\_\_\_

30. Have you had significant past trauma?  No  Yes

31. Have you previously seen a chiropractor?  No  Yes

If yes, what were the results?  Great  Good  Fair  Mixed  Poor  Other

32. Anything else pertinent to your visit today? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_