

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?

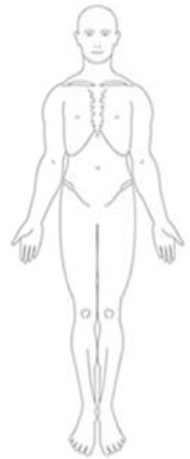
- Excellent Very Good Good Poor

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.

Past Present

- Headaches
- Neck Pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain
- Shoulder Pain
- Elbow/Upper Arm Pain
- Wrist Pain
- Hand Pain
- Hip Pain
- Upper Leg Pain
- Knee Pain
- Ankle/Foot Pain
- Jaw Pain
- Joint Pain/Stiffness
- Arthritis
- Rheumatoid Arthritis
- Cancer
- Tumor
- Asthma
- Chronic Sinusitis
- Other: _____

Past Present

- High Blood Pressure
- Heart Attack
- Chest Pain
- Stroke
- Angina
- Kidney Stones
- Kidney Disorders
- Bladder Infection
- Painful Urination
- Loss of Bladder Control
- Prostate Problems
- Abnormal Weight Gain/Loss
- Loss of Appetite
- Abdominal Pain
- Ulcer
- Hepatitis
- Liver/Gall Bladder Disorder
- General Fatigue
- Muscular Incoordination
- Visual Disturbances
- Dizziness

Past Present

- Diabetes
- Excessive Thirst
- Frequent Urination
- Smoking/Tobacco Use
- Drug/Alcohol Dependence
- Allergies
- Depression
- Systemic Lupus
- Epilepsy
- Dermatitis/Eczema/Rash
- HIV/AIDS

For Females Only

- Birth Control Pills
- Hormonal Replacement
- Pregnancy

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: _____

AUTO ACCIDENT INTAKE FORM

Patient Name: _____ Date: _____

1. Where was the accident located? _____ Date _____ Time _____ am
pm

2. How many vehicles were involved in the accident? 1 2 3 4 More

3. What was the estimated damage, in dollars, to the vehicle you were in? \$ _____

4. What type of impact was the auto accident?

- Rear End Frontal Passenger Broadside
 Driver Broadside Other: _____

5. How did the accident occur? _____

6. What did your vehicle do immediately after the accident?

- Hit another vehicle Spin around Roll Other

7. Where were you sitting in the vehicle during the accident?

- Driver Front Passenger
 Rear Left Passenger Rear Right Passenger Other _____

8. Did you know the accident was coming? Unaware Aware and Relaxed Aware and Braced

9. What type of vehicle were you in?

- Subcompact Compact Mid Size Full Size Truck
 SUV Minivan Other _____

10. What type of vehicle impacted yours?

- Subcompact Compact Mid Size Full Size Truck
 SUV Minivan Other _____

11. At the time of impact, was your vehicle moving? Yes No

if yes, how fast? _____ mph, Slowing Gaining Speed Steady

12. At the time of impact, how fast was the other vehicle moving? _____ mph

Slowing Gaining Speed Steady

13. During and after the crash, what happened to your vehicle? (circle all that apply)

- | | |
|---|--|
| <input type="checkbox"/> kept going straight | <input type="checkbox"/> spun around |
| <input type="checkbox"/> kept going straight hitting a car in front | <input type="checkbox"/> spun around and hit a stationary object |
| <input type="checkbox"/> was hit by another vehicle | <input type="checkbox"/> hit a stationary object |

14. Did you lose consciousness during the accident? Yes No

15. How was your head positioned during the accident? _____

16. Did your head hit anything during the accident? Yes No

please describe _____

17. Did your shoulders hit anything during the accident? Yes No

please describe _____

18. Did your chest hit anything during the accident? Yes No

please describe _____

19. Did your knees hit anything during the accident? Yes No

please describe _____

20. What kind of headrest was in your vehicle?

movable fixed headrest

nonmovable fixed headrest

no headrest

21. Did you have your seatbelt on during the accident? Yes No Shoulder Harness

Lap Belt Only

Other

22. Did you go to the hospital?

if no, why (and do not answer 38-43) _____

23. How did you get to the hospital? _____

24. What was the name of the hospital? _____

25. Check what you were prescribed at the hospital

Pain Medication

Muscle Relaxers

Neck Brace

Other

26. Did you receive any stitches for any cuts at the hospital? Yes No

27. Were X-rays taken at the hospital? Yes No

if yes, which area was taken? _____

28. Have you seen any other physicians or received any treatment? Yes No

if yes, describe _____

29. Have you missed any work as a result of the accident? Yes No How much? _____

30. Have you ever had any prior similar problems? Yes No

if yes, describe _____