# CHIROPRACTIC REGISTRATION AND HISTORY

## PATIENT INFORMATION

Date_____

Social Security #_____

Email _____

First Name_____

Last Name_____

Address _____

City_____

State_____ Zip_____

Sex M F Age_____

Birthdate_____

□ Married □ Widowed □ Single □ Minor

□ Separated □ Divorced □ Partnered for _____years

Patient Employer/School_____

Occupation_____

Employer/School Address_____

_____

Employer/School Phone (_____)_____

Spouse's Name _____

Birthdate_____

SS#_____

Whom may we thank for referring you?_____

## PHONE NUMBERS

Cell Phone (_____)_____

Home Phone (_____)_____

Best time and place to reach you _____

**IN CASE OF EMERGENCY, CONTACT**

Name_____ Relationship_____

Cell Phone (_____)_____

Work Phone (_____)_____

## INSURANCE INFORMATION

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co. _____

Group #_____

Is patient covered by additional insurance? □ Yes □ No

Subscriber's Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Co. _____

Group #_____

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Chiropractic and Health Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

## ACCIDENT INFORMATION

Is this condition due to an accident? □ Yes □ No

Date_____

Type of accident □ Auto □ Work □ Home □ Other

To whom have you made a report of your accident?

□ Auto Insurance □ Employer □ Workers Comp □ Other

Attorney Name (If applicable)_____

## PATIENT CONDITION

Reason for Visit_____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

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 it interfere with your Work Sleep Daily Routine Recreation

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