

CHIROPRACTIC REGISTRATION & HISTORY

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name _____
First Name _____ Middle Initial _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

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 _____
Name of Insurance Company(ies)

Dr. _____ 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

PHONE NUMBERS

Home Phone (____) _____ Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

ACCIDENT INFORMATION

Is 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 Worker 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) _____

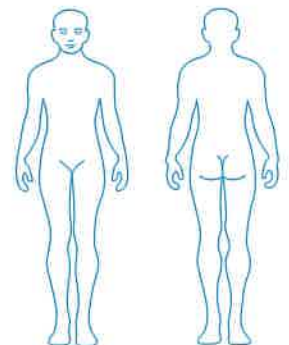
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

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



HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
		Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

EXERCISE

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

HABITS

- Smoking _____ Packs/Day _____
- Alcohol _____ Drinks/Week _____
- Coffee/Caffeine Drinks _____ Cups/Day _____
- High Stress Level _____ Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

Pharmacy Name _____
 Pharmacy Phone (____) _____

Patient Name: _____

Date: _____

Chief Complaint – HPI (History of Present Illness)

Patient Name: _____ Case: _____ Date: _____

Body Area(s) Involved: Choose the condition that applies to you and rate your level of impairment.

- Cervical
- Spine, Ribs, Pelvis
- Upper Extremity
- Lower Extremity

Body area #1: _____

	<u>Level of Impairment Due to Symptoms (Resting):</u>									
0	1	2	3	4	5	6	7	8	9	10

Level of Impairment Due to Symptoms (With Activity):

0	1	2	3	4	5	6	7	8	9	10

Body area #2: _____

	<u>Level of Impairment Due to Symptoms (Resting):</u>									
0	1	2	3	4	5	6	7	8	9	10

Level of Impairment Due to Symptoms (With Activity):

0	1	2	3	4	5	6	7	8	9	10

- Condition:** New → Acute or Chronic
- Recurrence (Acute) Exacerbation (Acute) Chronic

Mechanism of Onset:

- Auto: Driver/Passenger Pedestrian (refer to completed auto accident history form)
- Work Related: Fall Falling Object Lifting Overexertion Repetitive Motion
- Other: _____
- Liability: Slip or Fall Other: _____
- Other – No Liability: Etiology Unknown Overexertion Repetitive Use Slept Wrong Slip or Fall
- No Injury

Description of Onset of Complaint: _____

- Current Symptoms:** Pain Numbness Stiffness Weakness

Location: Left/Right/Bilateral _____

- Quality:** Burning Diffuse Dull/Aching Localized Radiating Sharp Shooting
- Stabbing Throbbing Tightness Tingling Other _____

Duration: Started: _____

Last Occurred: _____ Last episode: _____ Resolved Previous

Visit: _____

Worsened: _____ Injury Occurred: _____ Accident

Occurred: _____

Timing: Worse: Morning Afternoon Night with Activity; Constant Intermittent

Context: Better with: Warm Temp Cold Temp Worse with: Warm Temp Cold Temp

Damp

- Assoc Signs and Symptoms:** Blurred Vision Depression Dizziness Irritability/Mood Swing
- Localized Tingling Nausea Ringing in Ears Sleep Disturbance Stiffness

- Headaches:** Location: Occipital Frontal Left Temporal Right Temporal Parietal Sinus
- Quality: Dull Sharp Throbbing Stabbing Aura No Aura
- Types: Hat Band Cluster Migraine Tension
- Other: (frequency/duration/time of day) _____

Patient Name: _____

Date: _____

Radiation: Left / Right / Bilateral _____

Weakness: Left / Right / Bilateral _____

Other Assoc Signs and Symptoms:

- aches
- ecchymosis
- muscle spasm
- panic
- swelling
- burning
- chronic fatigue
- muscle weakness
- pins & needles
- tingling
- cold limb(s)
- fever
- nausea
- rhinorrhea (runny nose)
- vomiting
- difficulty walking
- heartburn
- numbness
- shortness of breath
- dizziness
- joint stiffness
- pale bluish skin
- sweating

Modifying Factors:

- Symptoms Better With: nothing helps activity bending applying cold applying heat
- massage movement OTC meds Rx meds rest
- stretching sitting standing twisting walking
- Symptoms Worse With: (as noted in Social History)

Daily Activities: Effects of Current Condition on Performance

- Bending: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Care –Infirm Family: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Carrying Groceries: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Change Posn–Sit–Stand: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Climb Stairs: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Driving: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Extended Computer Use: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Feeding: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Household Chores: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Kneeling: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Lifting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Pet Care: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Reading (Concentration): No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care–Bathing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care–Dressing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Sexual Activities: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Sleep: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Static Sitting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Static Standing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Walking: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Yard Work: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Employment:

Occupation/Job Title: _____ Work: _____ hrs/day or week

Description of Work: _____

Condition's Effect On Job Performance:

- Mild Painful (Can do) Mod Painful (limited ability) Mod/Sev Limited Duty Sev No Limited Duty Sev (can't do limited duty)

Recreational Activity: Effects of Current Condition on Performance

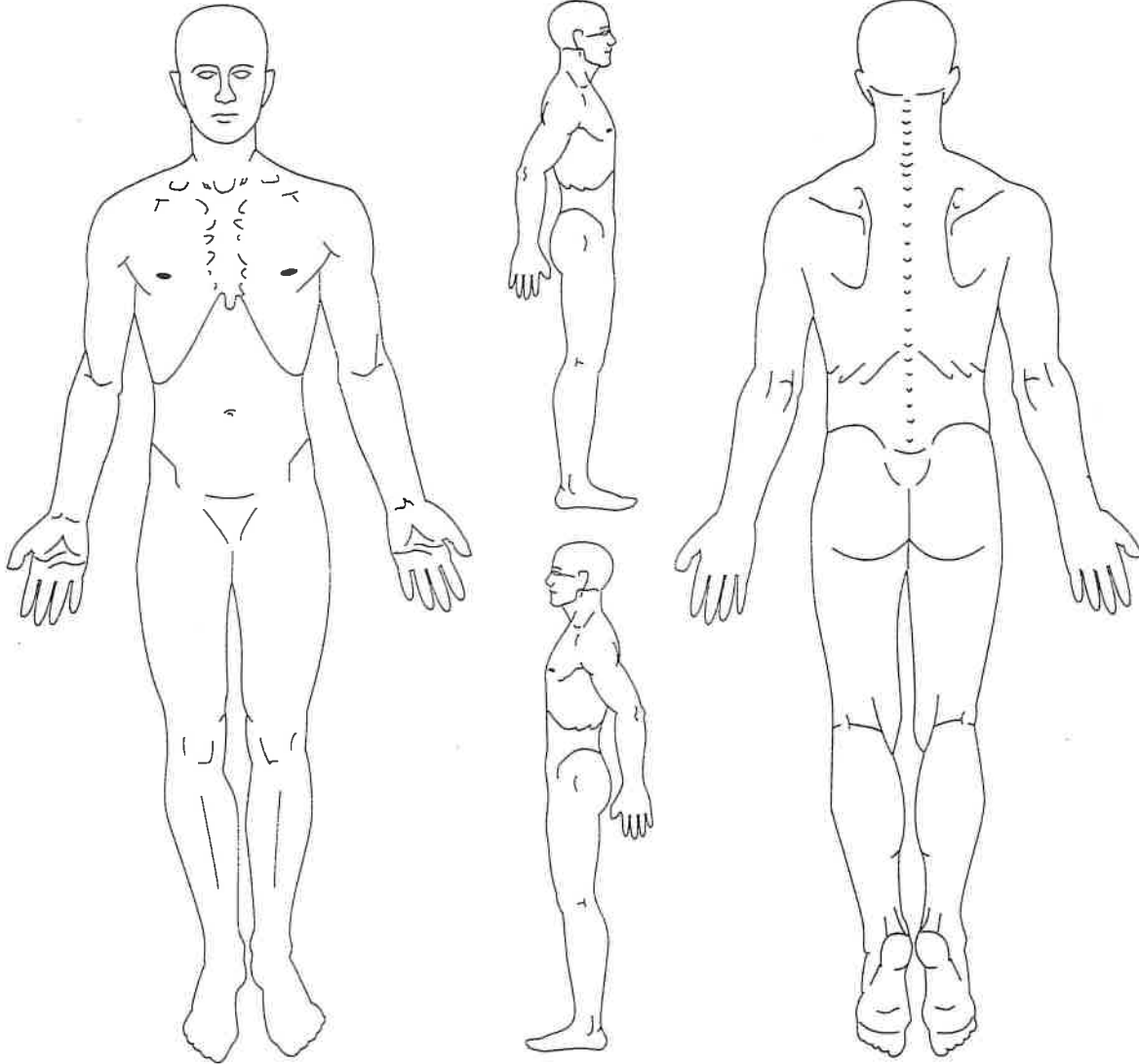
- _____ No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- _____ No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Patient Name(Print) _____ Date _____

Patient ID # _____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

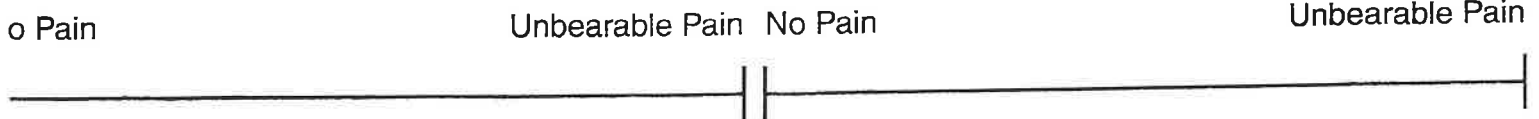
- D** = Dull
- B** = Burning
- N** = Numb
- S** = Stabbing/Cutting
- T** = Tingling (Pins & Needles)
- C** = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now**:

Rate your pain at its **best** in the past week:



Rate your **average** pain in the past week:

Rate your **worst** pain in the past week:

