

Patient Registration Form

Name: _____ Hm Phone: _____ Wk Phone: _____

Sex M/F: _____ Single/Married/Divorced/Widowed: _____ CellPhone: _____

email address: _____

Home Address: _____ City/State: _____ Zip: _____

Spouse's Name: _____ Wk Phone: _____

Nearest Relative not living with you: _____ Phone: _____

Nearest friend not living with you: _____ Phone: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Landlord: _____ Phone: _____

Whom may we contact in the case of an emergency?

_____ Phone: _____

Whom may we thank for referring you to us?

_____ Phone: _____

Social Security #: _____ Date of Birth: _____

Who is responsible for this bill? _____

I will be paying today by cash _____ check: _____ credit card: _____

I voluntarily consent to receive medical and healthcare services that may include diagnostic procedures, examinations, and treatment. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature

Date

Parent (if minor)

Date

Chiropractic Case History

Name _____ Sex M F Date _____

Address _____ State _____ Zip _____

H. Phone(_____) _____ W. Phone _____ Date of Birth _____ Age _____

Referred by _____ Social Security # _____

Occupation _____ Employer _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

1. Primary reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____

2. Chief Complaint: _____

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

4. Past Health History:

A. Previous illnesses you've had in your life: _____

B. Previous injury or trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

What was the date of the beginning of your last menstrual period? _____

5. Family Health History:

Associated health problems of relatives: _____

Deaths in immediate family:

Cause of parents or siblings death	Age at death
_____	_____
_____	_____
_____	_____

6. Social and Occupational History:

A. Level of Education:

high school some college college graduate post graduate studies

B. Job description: _____

C. Work schedule: _____

D. Recreational activities: _____

E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Parent or Guardian Signature _____ Date _____

Doctors Signature _____ Date _____

