Chiropractic Registration and History

Personal and Family Health History

Name ______________________________

Date ______________________________

Address ______________________________

City ____________ State ____ Zip ____________

Phone: (H) ______________________________

(Cell) ______________________________

E-mail ______________________________

Date of Birth ________________ Age ________

Sex Male Female

If Female, are you currently pregnant? Yes No

Family Doctor ______________________________

Referred By ______________________________

Occupation ______________________________

Employer ______________________________

Marital Status S M D W

Spouse's Name ______________________________

Spouse's Occupation ______________________________

In case of Emergency, Contact

Name ______________________________

Relationship ______________________________

Phone: (W) ______________________________

(Cell) ______________________________

Number of Children, Ages, and Previous Chiropractic Care?

Name ________________________ Age ________ Yes___ No____ Reason ________________
Name ________________________ Age ________ Yes___ No____ Reason ________________
Name ________________________ Age ________ Yes___ No____ Reason ________________
Name ________________________ Age ________ Yes___ No____ Reason ________________
Name ________________________ Age ________ Yes___ No____ Reason ________________

Insurance:

Who is responsible for this account? ______________
Relationship to Patient______________________
Insurance Company ______________________
Group # ____________ ID # ____________
Is patient covered by additional Insurance: Y N
Subscriber's Name ______________________
Birth date ______________________
Relationship to Patient ______________________
Insurance Company ______________________
Group # ____________ ID # ____________

Assignment and Release:
I certify that I, and/or my dependent(s), have insurance coverage with ________________ and assign directly to 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 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 Date

______________________________ ________________
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Current Health Habits

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 ______________

Injuries/Surgeries you have had	Date
Falls ______________________________	_______
______________________________	_______
Head Injures ________________________	_______
______________________________	_______
Broken Bones _______________________	_______
______________________________	_______
Dislocation _________________________	_______
______________________________	_______
Surgeries ___________________________	_______
______________________________	_______
______________________________	_______

Current Health Condition

1. Present Complaint (be brief) Reason For Your Visit Today ________________________________

Pain or Problem started on _________________________

Pains are: (select all that apply)

Sharp Dull/Ache Burning
Constant Intermittent Occasional
Daily ___ times per Week/Month

What activities aggravate your condition/pain? _________
____

What activities lessen your condition/pain? ____________
____

Is condition worse during certain times of the day? _____
____

Does this condition interfering with your
Sleep Routine Work
Recreation Other ___________________________

Is this condition:
getting progressively worse staying the same
getting better Not sure

Other Doctors seen for this condition ________________
____

Any home remedies? ____________________________

2. Second Complaint (be brief) Reason For Your Visit Today ________________________________

Pain or Problem started on _________________________

Pains are:

Sharp Dull/Ache Burning
Constant Intermittent Occasional
Daily ___ times per Week/Month

What activities aggravate your condition/pain? _________
____

What activities lessen your condition/pain? ____________
____

Is condition worse during certain times of the day? _____
____

Does this condition interfering with your
Sleep Routine Work
Recreation Other ___________________________

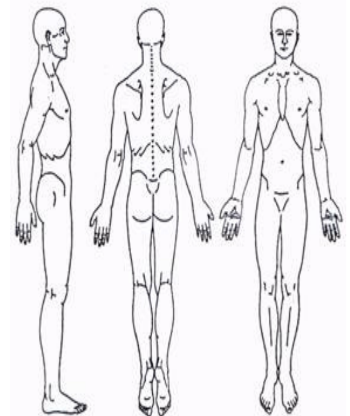
Is this condition:
getting progressively worse staying the same
getting better Not sure

Other Doctors seen for this condition ________________
____

Any home remedies? ____________________________

Other symptoms:

- Headaches
- Neck Pain
- Sleeping Problems
- Back Pain
- Nervousness
- Tension
- Irritability
- Chest Pains
- Dizziness
- Face Flushed
- Neck Stiff
- Pins & Needles in Legs
- Pins & Needles in Arms
- Numbness in Fingers
- Numbness in Toes
- Shortness of Breath
- Fatigue
- Depression
- Light Bothers Eyes
- Loss of Memory
- Ears Ring
- Fever
- Fainting
- Cold Sweats
- Loss of Smell
- Loss of Taste
- Diarrhea
- Feet Cold
- Hands Cold
- Stomach Upset
- Constipation
- Loss of Balance
- Buzzing in Ear



Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's Side					____________________
Mother's Side					____________________