## CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION	INSURANCE INFORMATION
Date	Who is responsible for this account?
SS/HIC/Patient ID #	Relationship to Patient
Patient Name	Insurance Co
Last Ivallie	Group #
First Name Middle Initial Address	Is patient covered by additional insurance?   Yes   No
E-mail	Subscriber's Name
City	Birthdate SS#
State Zip	Relationship to Patient
Sex M F Age	Insurance Co.
N:4	Group #
☐ Married ☐ Widowed ☐ Single ☐ Minor	ASSIGNMENT AND RELEASE I certify that I, and/or my dependent(s), have insurance coverage with
Separated Divorced Partnered for years	and assign directly to
Patient Employer/School	Name of Insurance Company(ies)
Occupation	Dr all insurance benefits, in any, otherwise payable to me for services rendered. I understand that I are
Employer/School Address	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
Employer/School Phone (	such information to the above-named Insurance Company(ies) and their agent for the purpose of obtaining payment for services and determining insurance
Imployer/School Phone ()	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.
Spouse's Name	
3irthdate	Signature of Patient, Parent, Guardian or Personal Representative
SS#	Please print name of Patient, Parent, Guardian or Personal Representative
Spouse's Employer	ricase print name of Fatient, Faterit, Guardian of Fersonal nepresentative
Vhom may we thank for referring you?	Date Relationship to Patient
PHONE NUMBERS	ACCIDENT INFORMATION
Cell Phone () Home Phone ()	Is condition due to an accident?   Yes  No Date
Best time and place to reach you	Type of accident
	To whom have you made a report of your accidents
N CASE OF EMERGENCY, CONTACT	To whom have you made a report of your accident?
	☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other
Name Relationship	
Name	Auto Insurance Employer Worker Comp. Other
	Auto Insurance Employer Worker Comp. Other
Name	Auto Insurance Employer Worker Comp. Other
Name Relationship Home Phone () Work Phone ()  PATIENT CONDITION	Attorney Name (if applicable)
Name Relationship Home Phone () Work Phone ()  PATIENT CONDITION  Reason for Visit  When did your symptoms appear? Is this condition getting progressively worse? Yes No Un	Attorney Name (if applicable)  known
Name Relationship Home Phone () Work Phone ()  PATIENT CONDITION  Reason for Visit When did your symptoms appear? Is this condition getting progressively worse? Yes No Un Mark an X on the picture where you continue to have pain, numbness	Attorney Name (if applicable)  known or tingling.
Name Relationship Home Phone () Work Phone ()  PATIENT CONDITION  Reason for Visit  When did your symptoms appear? Is this condition getting progressively worse? Yes No Un	Attorney Name (if applicable)  known or tingling.
Relationship	Attorney Name (if applicable)  known or tingling.  Aching Shooting
Relationship	Attorney Name (if applicable)  known or tingling.  Aching Shooting
Reason for Visit	Attorney Name (if applicable)  known or tingling.  Aching Shooting  Shooting
Relationship	Attorney Name (if applicable)  known or tingling. ere pain)  Aching Shooting Swelling Other  Recreation

HEALTH HISTORY									
What treatmen	t have you already red	ceived for your cond	ition?   Medicatio	ns 🗌 Surgery	☐ Physical Therap	oy .			
	☐ Chiropractic Service				· · · · · · · · · · · · · · · · · · ·				
Name and add	ress of other doctor(s	) who have treated y	ou for your conditi	ion		· · · · · · · · · · · · · · · · · · ·			
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 o	n "Yes" or "No" to ind	icate if you have had	any of the followi	ng:					
AIDS/HIV	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatoid Arthriti	s □ Yes □ No		
Alcoholism	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No		☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No		
Allergy Shots	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraine Headach		Scarlet Fever	☐ Yes ☐ No		
Anemia	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No		
Anorexia	☐ Yes ☐ No			Mononucleosis	· · · · · · · · · · · · · · · · · · ·	Suicide Attempt	☐ Yes ☐ No		
Appendicitis	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Multiple Sclerosis		Thyroid Problems	☐ Yes ☐ No		
Arthritis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No		
Asthma	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No		
	ders	Gout	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No		
Breast Lump	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's Disea		Typhoid Fever	☐ Yes ☐ No		
Bronchitis	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No		
Bulimia	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Venereal Disease			
Cataracts	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prostate Problem	•	Whooping Cough			
Chemical		High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other			
Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care					
EVEDCICE		WODE ACTIV		IIADITC					
EXERCISE □ None		WORK ACTIV  ☐ Sitting	III	HABITS  ☐ Smoking	Paci	cs/Day			
☐ Moderate				☐ Alcohol					
		☐ Standing							
	Daily Light Labor			Coffee/Caffeine Drinks Cups/Day					
☐ Heavy		☐ Heavy Labor		☐ High Stress Lev	vel Rea	son			
Are you pregnant?									
Injuries/Surgeri	es you have had		Description			Date	9		
Falls	<u>*</u>								
Head Inju	ıries								
Broken B									
Dislocatio	ns					-			
Surgeries									
MEDICATIONS A				ERGIES	VITAMIN	S/HERBS/N	IINERALS		
						•			
					-				
Pharmacy Nam	ne								
Pharmacy Pho	ne ()								