CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Sex: ☐M ☐F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____

Email _____

Occupation _____

Employer _____

Employer Phone _____ ext. _____

Spouse's Name _____

DOB _____ Occupation _____

Children (names) _____

Past Chiropractic Care? ☐Yes ☐No

When & Results? _____

Whom may we thank for referring you? _____

INSURANCE

Subscriber's name: _____

Relationship to subscriber: _____

Insurance Co. _____

ID# _____ Group #: _____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to patient _____

Insurance Co. _____

Group # _____

INSURANCE POLICY

We are not "In-Network" with any insurance companies except Medicare. We do not bill insurance directly. We collect our cash price up front and if you are interested in billing your insurance company for reimbursement we will supply you with a "super bill" which contains all of the required documentation for you to bill your insurance. As a courtesty, we will call your carrier to determine your "out of network" benefits.

PHONE NUMBERS

Cell _____ Home _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Cell 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) _____

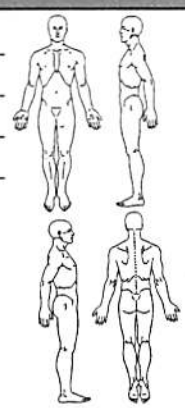
PATIENT INFORMATION

Reason for visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? _____

Where do 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 ☐Swelling

☐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

What treatment have you already or are presently receiving for your concerns? ☐None ☐Medications ☐Surgery ☐P.T.

☐Chiropractic ☐Acupucture ☐Other:

Lifestyle

Exercise	☐None ☐Light Activity ☐Moderate Activity ☐Active ☐Very Active ☐Elite Athlete
Diet	☐Very Poor ☐Poor ☐Fair ☐Somewhat Balanced ☐Very Balanced
Stress	☐None ☐Mild ☐Moderate ☐Very ☐Completely ☐Other _____
Habit	☐Smoking Pack/Day _____ TV Hours/day _____
	☐Alcohol Drinks/wk _____ ☐Coffee Cups/day _____

Medication

_____

_____

_____

_____

Supplements

_____

_____

_____

_____

Surgeries

Description	Date
_____	_____
_____	_____
_____	_____
_____	_____

Major Injuries & Accidents

(broken bones, falls, sports injuries, auto accidents, etc.)

Description	Date
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Is there a family history of:

☐ Heart Disease ☐ Cancer
☐ Arthritis ☐ Diabetes
☐ Thyroid Disorders ☐ Obesity
☐ Allergies ☐ Alzheimer's
☐ Other:

Health Goals

As a result of my chiropractic care, I would like to:

☐ Feel better quickly
☐ Have a healthier spine
☐ Have a healthier body by keeping my nervous system healthy
☐ Live a healthier lifestyle

To Our Patients

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. OUR ONLY PRACTIC OBJECTIVE is to eliminate a major interferences to the expression of the body's innate wisdom without drugs or surgery. Our only method is specific adjusting to correct vertebral subluxations.

Payments & Insurance

We request full payment at the time of service. We do not bill insurance. We will provide you with a "super bill" which will have all of the required documentation you will need to get reimbursed by your insurance company. As a courtesy, we will call your insurance carrier to determine your out-of-network benefits.

Missed Appointments

If we do not receive 24 hour notice of cancellation, there will be a missed appointment charge of $25. Your appointment times are reserved especially for you and without ample notification of change, someone else in need of care might have to be turned away.

I understand and agree to the following:

--A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes.
--My case may not be accepted for the treatment at this office.
--If the doctor believes that I may respond to their care, additional service may be recommended and I will be advised of applicable cost.

Patient (or Guardian) Signature: _____ Date: _____