CHIROPRACTIC REGISTRATION AND HISTORY

Date	Who is responsible for this account?
	Relationship to Patient
SS/HIC/Patient ID #	
Patient NameLast Name	Insurance Co.
First Name Middle Initial	Group #
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.
Birthdate	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 Name of Insurance Company(ies)
Patient Employer/School	
Occupation	Drall insurance benefits, i any, otherwise payable to me for services rendered. I understand that I am
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 agents for the purpose of obtaining payment for services and determining insurance
	benefits or the benefits payable for related services. This consent will end wher my current treatment plan is completed or one year from the date signed below.
Spouse's Name	
Birthdate	Signature of Patient, Parent, Guardian or Personal Representative
SS#	Discourse of Definite Description on Description
Spouse's Employer	Please print name of Patient, Parent, Guardian or Personal Representative
Whom may we thank for referring you?	Date Relationship to Patient
	A COLDENT INFORMATION
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 Auto Work Home Other
IN CASE OF EMERGENCY, CONTACT	To whom have you made a report of your accident?
Name Relationship	Auto Insurance Employer Worker Comp. Other
Home Phone () Work Phone ()	Attorney Name (if applicable)
PATIENT CONDITION	
9	
Reason for Visit	2 2
When did your symptoms appear?	
Is this condition getting progressively worse? Yes No Unk Mark an X on the picture where you continue to have pain, numbness,	
Rate the severity of your pain on a scale from 1 (least pain) to 10 (sever	
Type of pain: Sharp Dull Throbbing Numbness	
How often do you have this pain?	
Is it constant or does it come and go?	

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down

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What treatment I	have you al	Iready re	ceived for your condi	tion? 🗌 N	ledication	s 🗌 Surgery 🔲	Physica	al Therapy	/			
	-		ces 🗌 None 🔲 O				1000					
Name and addre	ess of other	doctor(s) who have treated y	ou for you	ir condition	n						
Date of Last: Physical Exam			Spinal X-Ray		Blood Test							
Spinal Exam			Chest X-Ray Urine				rine Test			a starte		
Dental X-Ray				MRI, CT-Scan, Bone Scan								
Place a mark on	"Yes" or "N	lo" to ind	icate if you have had	any of the	e following	r.						
AIDS/HIV	□ Yes	No	Diabetes	Yes	□ No	Liver Disease	Yes	□ No	Rheumatic Fever	□ Yes	□ No	
Alcoholism	□ Yes		Emphysema	□ Yes	a Contractor	Measles	Yes	□ No	Scarlet Fever	☐ Yes	□ No	
Allergy Shots	□ Yes	🗆 No	Epilepsy	□ Yes	□ No	Migraine Headaches	☐ Yes	□ No	Sexually			
Anemia	☐ Yes	□ No	Fractures	□ Yes	□ No	Miscarriage	☐ Yes	□ No	Transmitted Disease	☐ Yes	□ No	
Anorexia	□ Yes	□ No	Glaucoma	□ Yes	□ No	Mononucleosis	☐ Yes	□ No	Stroke	☐ Yes		
Appendicitis	□ Yes	□ No	Goiter	□ Yes	□ No	Multiple Sclerosis	Ves	□ No	Suicide Attempt	□ Yes		
Arthritis	□ Yes	□ No	Gonorrhea	🗌 Yes	🗆 No	Mumps	□ Yes	🗆 No	Thyroid Problems	□ Yes		
Asthma	□ Yes	🗆 No	Gout	🗆 Yes	🗌 No	Osteoporosis	☐ Yes	🗆 No	Tonsillitis	☐ Yes		
Bleeding Disorde	ers 🗌 Yes	🗆 No	Heart Disease	□ Yes	🗆 No	Pacemaker	Ves	🗆 No	Tuberculosis	☐ Yes		
Breast Lump	☐ Yes	🗆 No	Hepatitis	🗆 Yes	🗌 No	Parkinson's Disease	Yes	🗆 No	Tumors, Growths	Yes		
Bronchitis	🗌 Yes	🗆 No	Hernia	🗌 Yes	🗆 No	Pinched Nerve	🗌 Yes	🗆 No	Typhoid Fever	☐ Yes		
Bulimia	☐ Yes	🗆 No	Herniated Disk	🗆 Yes	🗆 No	Pneumonia	□ Yes	🗌 No	Ulcers	Yes	No	
Cancer	🗌 Yes	🗆 No	Herpes	□ Yes	🗌 No	Polio	☐ Yes	🗆 No	Vaginal Infections	□ Yes		
Cataracts	🗌 Yes	🗆 No	High Blood			Prostate Problem	🗌 Yes	🗆 No				
Chemical			Pressure	☐ Yes	□ No	Prosthesis	🗌 Yes	🗆 No	Whooping Cough	-	□ No	
Dependency	☐ Yes		High Cholesterol	☐ Yes	□ No	Psychiatric Care	🗌 Yes	🗌 No	Other			
Chicken Pox	L Yes	□ No	Kidney Disease	□ Yes		Rheumatoid Arthritis	☐ Yes	🗌 No				
EXERCISE			WORK ACTIV	ITY		HABITS						
□ None □ Sitting				1.54	Smoking		Pack	Packs/Day				
☐ Moderate ☐ Standing							Drinks/Week					
Daily Daily				Coffee/Caffeine Drinks			rinks	Cups/Day				
Heavy Heavy			High Stress Level				Reason					
								Tiode		-		
Are you pregnan	nt? 🗌 Yes	🗆 No	Due Date									
Injuries/Surgeries you have had Description Date												
Falls			and the second of the					100				
Head Injuri	es	- Starter										
							1920	True	1000 1200	29.0	30	
Broken Bo	544 B			1		1.			The second		1000	
Dislocations												
Surgeries												
		-					1000	10.15 24.15		10000		

S/HERBS/MINERALS