chiropractic

remove obstacles • restore function • improve performance • maximize potential

Patient Registration

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

confidential health information

clinic id	date

1 PATIENT CONTACT

last name	first name	m.i.

preferred to be called

street

city	state	zip

home phone	mobile phone

work phone	e-mail

2 PATIENT PERSONAL

age	date of birth	social security #	sex	☐ male	☐ female

status ☐ single ☐ married ☐ partnered ☐ widowed ☐ separated ☐ divorced

3 EMERGENCY CONTACT

name	home phone

relationship	work phone

4 SPOUSE OR GUARDIAN

last name	first name	m.i.

employer name

work phone	date of birth	social security #

5 PATIENT EMPLOYMENT

employer name	occupation

street

city	state	zip

Which one of our patients referred you to our clinic?

Today we will conduct a thorough history, consultation, and preliminary screening. If we believe we may be able to help you, we may recommend other diagnostic testing necessary to evaluate your condition. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes. I am requesting these services
- My case may not be accepted for treatment at this clinic
- If the doctors believe 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

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Account Information

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clinic id | date

1 PATIENT INFORMATION

last name	first name	m.i.

age	date of birth	social security #	sex		
				☐ male	☐ female

Are you here because you were involved in a vehicle collision? ☐ yes ☐ no

Are you here because you were injured at your place of employment? ☐ yes ☐ no

Are you here because you were involved in another type of accident? ☐ yes ☐ no

Who is responsible for this account?

Will you be using health insurance to supplement payment to our office*? ☐ yes ☐ no

* If YES, please complete the INSURANCE COVERAGE and INSURED INFORMATION sections of this form.

2 INSURANCE COVERAGE

type of insurance

☐ employee group health plan ☐ personal health insurance ☐ health savings account ☐ Medicare ☐ Medicaid

☐ personal injury ☐ Workers' Compensation ☐ TRICARE/CHAMPUS ☐ CHAMPVA ☐ FECA

primary insurance company	primary ins ID#	primary ins group#
secondary insurance company	**secondary ins ID#**	**secondary ins group#**

3 INSURED INFORMATION

Are the insured and patient the same person? ☐ yes ☐ no If YES, do not complete section 3.

last name	first name	m.i.

street

city	state	zip

age	date of birth	social security #	sex		
				☐ male	☐ female

relationship to insured ☐ spouse ☐ dependent ☐ Other _____

We are here to service our patients the best way we know how. We understand the value of health insurance. However, because health insurance plans are intended only to supplement out of pocket expenses for care, it may not cover all the care you need. We will verify your applicable insurance benefits and report the supplemental coverage to you.

Our relationship is with each patient individually, not the insurance companies. If we believe that we may be able to help you and we accept your case, our recommendations will be based on what we believe is best for you - supported by our experience. We take great care in making our services affordable regardless of health insurance coverage.

I understand and agree to the following:

- There is no guarantee that my health insurance plan or policy will pay for all or part of my care
- I will be informed of fees and charges before the associated procedure or service is performed
- As the patient or guardian of a patient, I am ultimately responsible for all charges incurred from services rendered

patient or guardian signature

date

1 BENEFITS ASSIGNMENT

I authorize that payment of charges be made directly to the doctor(s) of this clinic. This authorization includes:

1. All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy
2. Amounts owed on my behalf from proceeds of any settlement related to my case.

patient or guardian signature _____ date _____

2 INFORMATION RELEASE

I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan to request payment benefits to me or my assignee.

patient or guardian signature _____ date _____

INSURANCE VERIFICATION

OFFICE USE ONLY – Please Do Not Write In This Box

Is this a **Workers' Comp** case? ☐ yes ☐ no

- Has the injury been reported? ☐ yes ☐ no
  - Name:
  - Title:
  - Is patient currently employed at place of injury? ☐ yes ☐ no
  - Name of person authorizing care:

Is this an **Auto Collision** or **Personal Injury** case? ☐ yes ☐ no

- Has it been reported to the insurance company? ☐ yes ☐ no
- Has an application for benefits been filed? ☐ yes ☐ no
- Did the police write a report? ☐ yes ☐ no
- Is auto or PI insurance primary? ☐ yes ☐ no
- Agent name and contact info:

Does the plan cover the following services?

- chiropractic adjustments ☐ yes ☐ no
- modalities:
  - hot/cold packs ☐ yes ☐ no
  - mechanical traction ☐ yes ☐ no
  - electric stimulation ☐ yes ☐ no
  - ultrasound ☐ yes ☐ no
- therapeutic exercise and activities ☐ yes ☐ no
- neuromuscular re-education ☐ yes ☐ no
- massage ☐ yes ☐ no
- manual therapy technique ☐ yes ☐ no
- exams ☐ yes ☐ no
- supports, braces, collars ☐ yes ☐ no
- pillows ☐ yes ☐ no
- nutritional supplements ☐ yes ☐ no
- orthotics ☐ yes ☐ no
- other:_____ ☐ yes ☐ no
- other:_____ ☐ yes ☐ no

Does the plan have a deductible? ☐ yes ☐ no

- Amount for an individual:
- Amount for the family:
- Amount currently met:
- When does the deductible renew?
- Do charges for diagnostic tests apply to the deductible?

What is the co-pay after the deductible is met?

What is the maximum yearly benefit?

What is the yearly visit cap?

Does the company assign benefits to the doctor? ☐ yes ☐ no

Are any special forms required to file claims? ☐ yes ☐ no

What is the name of the person that you spoke with?

- Last:
- First:
- ID# Extension:

Notes:

CHIROPRACTIC HISTORY

Patient Name: _____ Initial Exam: ___/___/

CHIEF COMPLAINT(S):

#1 Complaint: _____

#2 Complaint: _____

#3 Complaint: _____

#4 Complaint: _____

ONSET:

When did the pain start? _____

❑ Traumatic ❑ Insidious Onset? _____

_____

PROVOKE:

What makes the pain worse? _____

_____

_____

PALLIATIVE:

What makes the pain better? _____

_____

_____

DO YOU FEEL LIKE THIS CONDITION IS GETTING WORSE?

❑ Yes ❑ No ❑ Unsure

HAVE YOU HAD SIMILAR COMPLAINTS BEFORE?

❑ Yes ❑ No ❑ Unsure

QUALITY:

What does the pain feel like?

❑ Sharp ❑ Dull ❑ Burns ❑ Shooting ❑ Crushing ❑ Throbbing ❑ Achy ❑ Stiff ❑ Numb
❑ Tingling

Other: _____

_____

RADIATION:

Does the pain move or radiate? ❑ Yes ❑ No

If yes, describe: _____

_____

_____

RESTRICTIONS:

Does the pain stop you from doing any of your normal activities?

❑ Yes ❑ No

If yes, describe: ❑ Sleep ❑ Work ❑ Recreation ❑ Daily Routine

_____

_____

SEVERITY

(1-10 with 10 being worst) Now _____ Average _____ Best _____ Worst _____

SEQUELA:

Have you had any conditions in the past that left you with ongoing problems?

❑ Yes ❑ No

If yes, describe: _____

_____

TIMING

Is the pain:

❑ Constant ❑ Intermittent

❑ Better in am ❑ Worse in am

❑ Better in pm ❑ Worse in pm

Has this pain ever occurred before? ❑ Yes ❑ No. If yes, when? _____

 # OF TIMES PER WEEK YOU HAVE THIS PROBLEM?

❑ Every day ❑ _____

PREVIOUS TREATMENT(S) FOR THIS CONDITION:

❑ OTC Meds ❑ Rx Meds ❑ Chiropractic ❑ Physical Therapy ❑ Ice ❑ Heat

❑ Exercise ❑ Rest

❑ Others _____

PREVIOUS SURGERIES:

_____

_____

_____

OTHER COMPLAINTS:

_____

_____

_____

NOTES:

_____

_____

_____

Dr Signature: _____ Date: ___/___/___

Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other _____

_____

Medical (Men)

- ❑ Benign prostatic hyperplasia
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ Sexually transmitted disease

Other _____

_____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ Premenstrual syndrome (PMS)
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ Sexually transmitted disease

Other _____

Date of last GYN exam _____

Mammogram ❑ + ❑ –

PAP ❑ + ❑ –

Form of birth control _____

# of children _____

# of pregnancies _____

❑ C-section _____

Age of first period _____

Date - last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

- ❑ Surgical menopause
- ❑ Menopause

Family Health History (Parents and Siblings)

- ❑ Arthritis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other _____

Health Habits

❑ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

❑ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

❑ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine: #cans/d _____

Other sources _____

❑ Water: #glasses/d _____

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk - #days/wk _____
- ❑ Run, jog, other aerobic - #days/wk _____
- ❑ Weight lift - #days/wk _____
- ❑ Stretch - #days/wk _____
- ❑ Other _____

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs

❑ soy ❑ corn ❑ all gluten

Other _____

Food Frequency

Number of servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

❑ Skip meals - which ones _____

_____

- ❑ One meal/day
- ❑ Two meals/day
- ❑ Three meals/day
- ❑ Graze (small frequent meals)
- ❑ Generally eat on the run
- ❑ Eat constantly whether hungry or not

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source _____
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe _____
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveratrol, etc.)
- ❑ Herbs
- ❑ Homeopathy
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals (Ensure)

Others _____

_____

I Would Like To:

ENERGY - VITALITY

- ❑ Feel more vital
- ❑ Have more energy
- ❑ Have more endurance
- ❑ Be less tired after lunch
- ❑ Sleep better
- ❑ Be free of pain
- ❑ Get less colds and flu
- ❑ Get rid of allergies
- ❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ❑ Stop using laxatives and stool softeners
- ❑ Improve sex drive

BODY COMPOSITION

- ❑ Loose weight
- ❑ Burn more body fat
- ❑ Be stronger
- ❑ Have better muscle tone
- ❑ Be more flexible

STRESS, MENTAL, EMOTIONAL

- ❑ Learn how to reduce stress
- ❑ Think more clearly and be more-focused
- ❑ Improve memory
- ❑ Be less depressed
- ❑ Be less moody
- ❑ Be less indecisive
- ❑ Feel more motivated

LIFE ENRICHMENT

- ❑ Reduce my risk of degenerative disease
- ❑ Slow down accelerated aging
- ❑ Maintain a healthier life longer
- ❑ Change from a "treating-illness" orientation to creating a wellness lifestyle