CLINIC REGISTRATION AND PATIENT HISTORY

1. PATIENT INFORMATION

Date_____

SSN#_____

Patient Name_____
Last

_____
First Middle

Address_____

City _____

State_____ Zip Code_____

E-mail_____

Sex ___M ___F Age_____ DOB_____

__ Married __ Widowed __ Single __ Minor
__ Separated __ Divorced

Patient Employer/School_____

Occupation_____

Employer/School Address_____

_____

Employer/School Phone (_____)_____

Spouse's Name_____

DOB _____ SSN# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2. INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Phone # (_____)_____

Policy # _____

Group # _____

Is patient covered by additional insurance ___ Y ___ N

Subscriber's Name _____

DOB_____ SSN# _____

Relationship to patient _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with_____ and assign directly to _____ 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 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.

_____
Signature of Patient, Parent, Guardian or Personal Rep

_____
Print name of Patient, Parent, Guardian or Personal Rep.

_____
Date Relationship to Patient

3. PHONE NUMBERS

Cell (____)_____ Home Phone (____)_____
Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT
Name_____ Relationship_____

Home Phone (____)_____ Work Phone (____)_____

4. ACCIDENT INFORMATION

Is condition due to an accident? __Y __N Date _____

Type of Accident __ Auto __ Work __ Home __ Other

To whom have you made a report of your accident?

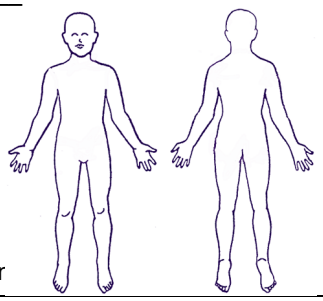
__ Auto Ins. __ Employer __ Worker Comp. __ Other

5. PATIENT CONDITION

Reason for Visit _____
When did your symptoms appear? _____
Is this condition getting progressively worse? ___Y ____N _____Unknown
Mark and X on the picture where 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 __Shooting
__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 Dowr



6. HEALTH HISTORY

What treatment have you already received for your condition? ____Medications ____Surgery ____Physical Therapy

____Chiropractic Services ____None ____Other_____

Name and address of other doctor(s) who have treated you for your condition _____

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_____

Please circle "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Diabetes	Yes	No	Liver Disease	Yes	No	Rheumatic Fever	Yes	No
Alcoholism	Yes	No	Emphysema	Yes	No	Measles	Yes	No	Scarlet Fever	Yes	No
Allergy Shots			Epilepsy			Migraine Headaches			Sexually Transmitted Disease	Yes	No
Anemia	Yes	No	Fractures	Yes	No	Miscarriage	Yes	No	Stroke	Yes	No
Anorexia	Yes	No	Glaucoma	Yes	No	Mononucleosis	Yes	No	Suicide Attempt	Yes	No
Appendicitis	Yes	No	Goiter	Yes	No	Multiple Sclerosis	Yes	No	Thyroid Problems	Yes	No
Arthritis	Yes	No	Gonorrhea	Yes	No	Mumps	Yes	No	Tonsillitis	Yes	No
Asthma	Yes	No	Gout	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Bleeding Disorder	Yes	No	Heart Disease	Yes	No	Pacemaker	Yes	No	Tumors, Growths	Yes	No
Breast Lump	Yes	No	Hepatitis	Yes	No	Parkinson's Disease	Yes	No	Typhoid Fever	Yes	No
Bronchitis	Yes	No	Hernia	Yes	No	Pinched Nerve	Yes	No	Ulcers	Yes	No
Bulimia	Yes	No	Herniated Disk	Yes	No	Pneumonia	Yes	No	Vaginal Infections	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No	Polio	Yes	No	Whooping Cough	Yes	No
Chemical Dependency	Yes	No	High Cholesterol	Yes	No	Prostate Problems	Yes	No	Psychiatric Care	Yes	No
Chicken Pox	Yes	No	Kidney Disease	Yes	No	Prosthesis	Yes	No	Rheumatoid Arthritis	Yes	No

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 _____

Are you pregnant? _____ Yes _____ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7. MEDICATIONS

_____
_____
_____
_____

Pharmacy Name_____

Pharmacy Phone_____

ALLERGIES

_____
_____
_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____
_____
_____