

#

---

---

**REGISTRATION FORM**

Date: \_\_\_\_\_

Name \_\_\_\_\_ SS: \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile (Cell) Phone \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status  M  S  W  D

Email \_\_\_\_\_ How Many Children? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Occupation \_\_\_\_\_

Patient's Nearest Relative \_\_\_\_\_ Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Referred by: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this healthcare office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this healthcare office will be credited to my account upon receipt. However, I clearly understand and agree that any services rendered me and charged directly to me and that I am personally responsible for payment. I also understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

\_\_\_\_\_ Initials

**Please Hand the Front Desk Personnel a Copy of Your Insurance Card**

Patient's Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_/

Name \_\_\_\_\_ Date \_\_\_\_\_ ID# \_\_\_\_\_

Describe your symptoms:

\_\_\_\_\_

\_\_\_\_\_

How did your symptoms begin?

Are your symptoms :  Improving  Getting Worse  Same

**RELEVANT MEDICAL HISTORY (Check if you have had in the past or present)**

<input type="checkbox"/> Arthritis/Osteoporosis	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Psychological problems
<input type="checkbox"/> Asthma/Sinus trouble	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Neck pain or spasms
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hand or wrist pain	<input type="checkbox"/> Neuritis/Numbness/Neuro disorders
<input type="checkbox"/> Back pain/Sciatica	<input type="checkbox"/> Headaches	<input type="checkbox"/> Thyroid or menstrual problems
<input type="checkbox"/> Concussion/Dizziness	<input type="checkbox"/> Hepatitis/Measles/T.B.	<input type="checkbox"/> M.S./Muscular dystrophy
<input type="checkbox"/> Digestion problems	<input type="checkbox"/> High/Low blood pressure	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/Aids/Blood infections	<input type="checkbox"/> Venereal diseases
<input type="checkbox"/> Heart	<input type="checkbox"/> Cancer	<input type="checkbox"/> Unexplained weight loss
<input type="checkbox"/> Gout	<input type="checkbox"/> Healing	<input type="checkbox"/> Frequent infections
<input type="checkbox"/> Kidneys	<input type="checkbox"/> Skin	<input type="checkbox"/> Liver
<input type="checkbox"/> Lungs	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Bladder
<input type="checkbox"/> Hormones	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Deep vein thrombosis

Do you have any artificial joints? Hip Yes \_\_\_ No \_\_\_ Knee Yes \_\_\_ No \_\_\_ Other? \_\_\_\_\_

Do you have a Heart Valve Implant? Yes \_\_\_\_\_ No \_\_\_\_\_

**FAMILY HISTORY:**

	Diabetes	Cancer	Heart	Lung	Thyroid	Living	Deceased	Cause
Mother								
Father								
Brother								
Sister								

**Is there a family (blood relative) history of:**

- Flatfeet
- Arthritis
- Stroke
- Bunions
- Diabetes
- Heart Disease
- Bleeding disorder
- Neurological disorder
- Hammertoes
- Circulation problems

Allergies to Medications:

**SOCIAL HISTORY:**

- Smoking history:**
- never smoked
  - quit (how long ago \_\_\_\_\_)
  - Smoke \_\_\_\_\_ pks/day for \_\_\_\_\_ yrs
- Alcohol History:**
- Never used
  - Have \_\_\_\_\_ drinks/week
  - have drank alcohol for \_\_\_\_\_ yrs

**ADDITIONAL HISTORY:**

Previous surgeries or hospital stays; Any recent exposures to communicable diseases or other concerns:

Instructed to see PCP

Have you been treated for any health conditions in the past year?

Have you ever seen a chiropractor?  Yes  No If yes, who? \_\_\_\_\_

For Podiatry patients; Shoe Size? \_\_\_\_\_

**Additional Information:**

\_\_\_\_\_

\_\_\_\_\_

Patients Signature \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_



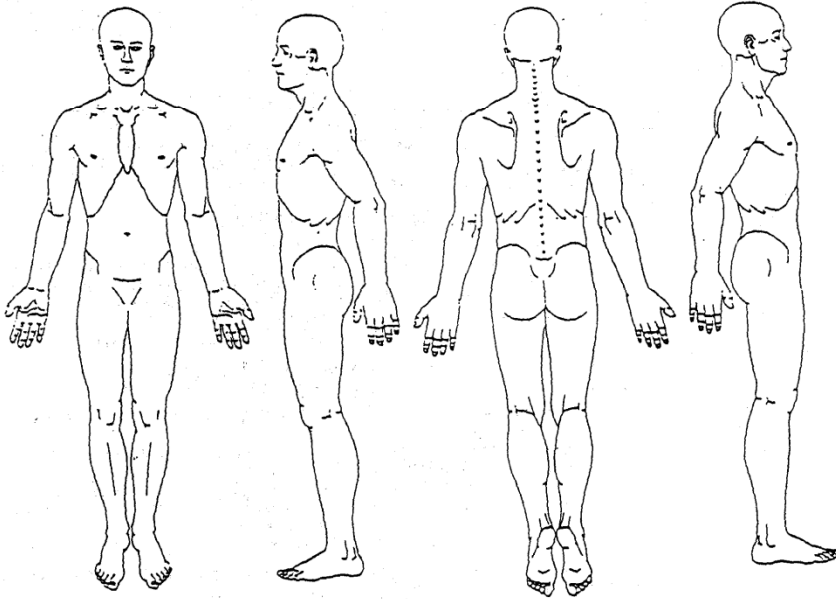
## PAIN DRAWING

DATE \_\_\_\_\_

NAME \_\_\_\_\_

Using the following descriptive symbols, draw the location of your pain on body outlines below.  
In addition, mark the level of your pain on the pain line at the bottom of the page.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
///	====	0000	.....	/////	XXXX
\\	===	00	.....	/////	XXX



No Pain |-----| Worst Possible Pain

Please make a slash through this line as to the level of your pain.

\_\_\_\_\_  
Patient Signature

(Over)