

#

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:	SOCIAL HISTORY:	ADDITIONAL HISTORY:
<input type="checkbox"/> Flatfeet	<input type="checkbox"/> Heart Disease	Previous surgeries or hospital stays; Any recent exposures to communicable diseases or other concerns:
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bleeding disorder	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Neurological disorder	
<input type="checkbox"/> Bunions	<input type="checkbox"/> Hammertoes	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Circulation problems	
Allergies to Medications:	<input type="checkbox"/> never smoked	Instructed to see PCP <input type="checkbox"/>
	<input type="checkbox"/> quit (how long ago _____)	
	<input type="checkbox"/> Smoke _____ pks/day for _____ yrs	
	Alcohol History:	
	<input type="checkbox"/> Never used	
	<input type="checkbox"/> Have _____ drinks/week	
	<input type="checkbox"/> have drank alcohol for _____ yrs	

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 ____ / ____ / ____

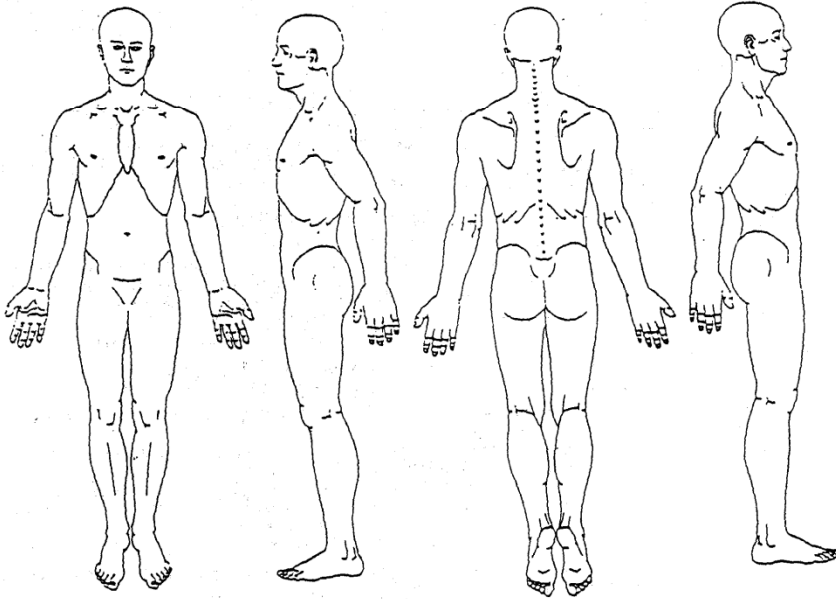
PAIN DRAWING

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)