## CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION	INSURANCE					
Date	Who is responsible for this account?					
Patient	Relationship to Patient					
Address	Insurance Co.					
WWW.	Group #					
City State Zip Sex: M F Age Birthdate	Is patient covered by additional insurance?  Yes No					
Sex: M P Age Distribute  Single Married Widowed Separated Divorced	BirthdateSS#					
	Relationship to Patient					
Patient SS#	Insurance Co.					
Occupation						
Employer	ASSIGNMENT AND RELEASE					
Employer Address	1, the undersigned certify that I (or my dependent) have insurance coverage					
Employer Phone	with and assign directly to					
Spouse's Name	Dr. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially					
BirthdateSS#	responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of					
Occupation	benefits. I authorize the use of this signature on all insurance submissions					
Spouse's Employer						
Whom may we thank for referring you?	Responsible Party Signature					
Within may we trank for retening you.	Relationship Date					
HomeWorkExt  Best time and place to reach you  IN CASE OF EMERGENCY, CONTACT  NameRelationship	Is condition due to an accident?  Yes No Date  Type of accident Auto Work Home Other  To whom have you made a report of your accident?  Auto Insurance Employer Worker Comp. Other  Attorney Name (if applicable)					
Home Phone Work Phone	, , , , , , , , , , , , , , , , , , , ,					
PATIENT CONDITION						
Reason for Visit						
When did your symptoms appear?	(==)					
Is this condition getting progressively worse? Yes No	Unknown					
Mark an X on the picture where you continue to have pain, numbr						
Rate the severity of your pain on a scale from 1 (least pain) to 10						
Type of pain: Sharp Dull Throbbing Numbness Burning Tingling Cramps Stiffness	☐ Aching ☐ Shooting ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐					
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						

		ady received for your	condition?	Medication	ns 🗌 S	urgery [	] Physica	al Therapy		
	Chiropractic	octor(s) who have tre	Annal	your condition	1	all and the second section of the second		1000 Sewalina Was State 1889		
		ctor(s) who have the			•	RI	ood Test			
Date of Last: F		The state of the second	Spinal X-Ray			Urine Test				
	Spinal Exam	The second secon	Chest X-F			mic reat	AND AND AND AND SERVICE OF THE SERVI	zwegotielezote 		
	Dental X-Ray_	en ja valanda kan kan kan kan kan kan kan kan kan ka	usasiev	Scan, Bone Sc			and the section of th	A COLOR DE CONTRACTO CONTRACTO DE SECURIO	Service and the	
Place a mark o	on "Yes" or "No"	to indicate if you ha				Free 1	7			□ Van □ Ni
AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ N			Account Service	No	Scarlet Feve Stroke	ı	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No		☐ Yes ☐ N		ucleosis	☐ Yes ☐	7 140	Suicide Atter	mot	hemoty#
Allergy Shots	☐ Yes ☐ No		☐ Yes ☐ N	Calar		☐ Yes ☐	No	Thyroid	p.	
Anemia	Yes No		☐ Yes ☐ N	A di comerce	S	Yes [	] No	Problems		☐ Yes ☐ No
Anorexia	Yes No		☐ Yes ☐ N	Cotoor	orosis	Yes [	] No	Tonsillitis		Yes No
Appendicitis	☐ Yes ☐ No		☐ Yes ☐ N	Pacam	aker	☐ Yes ☐	] No	Tuberculosis		Yes No
Arthritis	☐ Yes ☐ No		☐ Yes ☐ N	lo Parkins			7.51-	Tumors, Growths		☐ Yes ☐ N
Asthma Bleeding	Tes los INO	Hepatitis		Disec	ise id Nerve	Yes Yes		Typhoid Fev	or	☐ Yes ☐ N
Disorders	☐ Yes ☐ No		September Septem	PINCHE		☐ Yes [		Ulcers	C1	☐ Yes ☐ N
Breast Lump	Yes No		Burnetif Brown	lo Pneum	ionia	☐ Yes ☐		Vaginal		□ ,00 □ ,,
Bronchitis	☐ Yes ☐ No			lo Prosta	te	L] teaL	7 (40)	Infections		☐ Yes ☐ N
Bulimia	☐ Yes ☐ No			Probl		Yes [	No	Venereal		
Cancer	☐ Yes ☐ No		Yes N	110301	esis	Yes [	] No	Disease		Yes N
Cataracts	Yes No		and the same of th		atric Care	e 🗌 Yes 🗀	No	Whooping Cough		☐ Yes ☐ N
Chemical	FT No FT NO.	Liver Disease	Services to the Services	lo Rheun		TTVT	TALE	Other		hand 1777 hand
Dependency	Yes No	Modelico	☐ Yes ☐ N			Yes L	] No		a: Ampodon	
Chicken Pox Diabetes	☐ Yes ☐ No	migranio	□Yes□N	Aheun Io Feve	The state of the s	☐ Yes ☐	No	1,000,000		
Diabetes	1,100 [] 110		based based							
EXERCISE		WORK ACTIVI	TY	HABITS						
None		Sitting		Smoking			Packs/D	)ay	accompany definition	
				Alcohol			Drinks/V	Veek		
☐ Moderate ☐ Standing		Coffee/Caffeine Drinks			Cups/Day					
☐ Daily ☐ Light Labor			haded Total Control of the Control o					ROMOTRATOVAN		
☐ Heavy		☐ Heavy Labor		☐ High Stres	s Level		Reason			
Are you pregn	ant? Yes	☐ No Due Date			CAN DESCRIPTION					
Injuries/Surgeries you have had Description							Date			
Falls	Madestalaners					Name and Address of the Address of the	manufacture of the second control of	Companies to principles in the con-		and the format of the second s
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