CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Date : _____

Phone # : Home _____

Cell _____

Patient Name : _____

Address : _____

_____

City : _____

State : _____ Zip : _____

E-Mail : _____

Sex : M _____ F_____ AGE _____

Birthdate : _____

Married _____ Widowed _____ Single _____

Separated _____ Divorced _____ Minor _____

Employer/School : _____

Occupation : _____

PATIENT CONDITION

Reason for visit? _____

_____

When did your symptoms appear? _____

Is this condition getting progressively worse? Y__N__

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 Down____

Type of pain : Sharp____ Dull____Throbbing____

Aching____ Shooting____ Numbness____

Cramps____ Stiffness____ Swelling____Other____

INSURANCE INFORMATION

Do you have insurance? YES _____ NO _____

(Please give all insurance cards to front desk.)

Who is responsible for this account?

_____

Relationship to patient?

_____

Whom may we thank for referring you? _____

_____

IN CASE OF EMERGENCY CONTACT

Name : _____

Relationship : _____

Phone # : _____

ACCIDENT INFORMATION

Is condition due to an accident? YES ____ NO _____

Date of accident? _____

To whom have you made a report of your accident?

Auto Ins ___ Employer ___ Worker Comp ___ Other ___

Attorney, Name (if applicable) : _____

Mark an X on the picture where you continue to have pain, numbness, or tingling.