

# CHIROPRACTIC REGISTRATION HISTORY

## Patient Information

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

Name \_\_\_\_\_  
LAST NAME FIRST NAME INITIAL

Address \_\_\_\_\_

CITY STATE ZIP

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced  
SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

May we call you at work?  Y  N

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Children's Names and Ages \_\_\_\_\_

Would you like to receive an email of our optimal health newsletter?  Yes  No

Whom may we thank for referring you? \_\_\_\_\_

## Insurance

Who is responsible for this account? \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Is patient covered by additional insurance?  Y  N

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_

and assign directly to Five Points Chiropractic 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_

Date \_\_\_\_\_

## Phone Numbers

Home \_\_\_\_\_ Cell \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

Email \_\_\_\_\_

## IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone \_\_\_\_\_ Work \_\_\_\_\_

## 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 Insurance  Employer

Worker Comp  Other

Attorney Name (if applicable) \_\_\_\_\_

## Patient Condition

Reason for visit \_\_\_\_\_

When did your symptoms begin? \_\_\_\_\_

Is this condition getting worse?  Yes  No  Unknown

Mark an 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

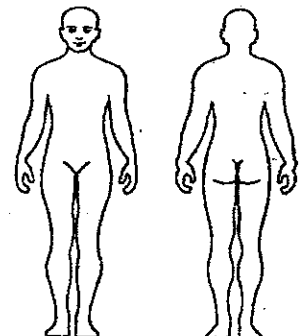
Is the pain constant or does it come and go? \_\_\_\_\_

How often do you have this pain? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform:

Sitting  Standing  Walking  Bending  Lying Down



# HEALTH HISTORY

Have you ever seen a Chiropractor before?  Yes  No

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 1st Treatment \_\_\_\_\_ Number of treatments in last 12 months \_\_\_\_\_

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 check  symptoms you currently have:**

- Balance Impairment     Headaches     Loss of Memory     Vertigo
- Burning Eyes     Lightheadedness     Nausea     Visual/Sensory Disturbance
- Depression     Loss of Concentration     Ringing/Buzzing in Ears

**Please check  conditions or symptoms you currently have or have had in the past:**

- |                                       |  |  |   |  |
|---------------------------------------|--|--|---|--|
| <input type="checkbox"/> AIDS/HIV     | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Herniated Disk      | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Anemia       | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Anorexia     | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Ulcers          |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Polio                | <input type="checkbox"/> Varicose Veins  |
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Jaw Pain/TMJ        | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Whiplash        |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Psychiatric Care     | Other _____                              |
| <input type="checkbox"/> Blood Clots  | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Rheumatoid Arthritis | _____                                    |
| <input type="checkbox"/> Breast Lump  | <input type="checkbox"/> Gout                | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Rheumatic Fever      | _____                                    |
| <input type="checkbox"/> Bronchitis   | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Scarlet Fever        | _____                                    |
| <input type="checkbox"/> Bulimia      | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Stroke               | _____                                    |
| <input type="checkbox"/> Cancer       | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Thyroid Problems     | _____                                    |

**EXERCISE**

- None     Daily  
 Moderate     Heavy

**WORK ACTIVITY**

- Sitting     Light Labor  
 Standing     Heavy Labor

**LIFESTYLE**

- Smoking Packs/Day \_\_\_\_\_     Coffee/Caffeine    Cups/Day \_\_\_\_\_  
 Alcohol    Drinks/Week \_\_\_\_\_     High Stress Level    Reason \_\_\_\_\_

Are you pregnant?  Yes  No    Due Date \_\_\_\_\_

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

**MEDICATIONS**

**ALLERGIES**

**VITAMINS/SUPPLEMENTS**

MEDICATION	TAKING FOR	
_____	_____	_____
_____	_____	_____
_____	_____	_____

# HEALTH HISTORY OF FAMILY MEMBERS

The reason for this form is to assist the doctor by providing past health history information for his review.

Condition	Self	Father	Mother	Spouse	Brothers	Sisters	Children
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Disc Problems							
Drinker							
Drug Addiction							
Emphysema							
Epilepsy							
Headaches							
Heart Trouble							
High Blood Pressure							
Kidney Trouble							
Migraine							
Nervousness							
Neuritis							
Neuralgia							
Pinched Nerve							
Sinus Trouble							
Smoker							
Sports Activities							
Stomach Trouble							
Deceased							