CHIROPRACTIC REGISTRATION AND HISTORY

| PATIENT INFORMATION | INSURANCE |
|---|--|
| | |
| Date | |
| Patient | ID # or Claim # |
| Address | Group # Is patient covered by additional insurance? Yes No |
| City State Zip | Insurance Co. 2 |
| Sex: M F AgeBirthdate | BirthdateSS# |
| Single Married Widowed Separated Divorced | Relationship to Patient |
| Patient SS# | ID # |
| Occupation | Group # |
| Employer | ASSIGNMENT AND RELEASE |
| Employer Address | I, the undersigned certify that I (or my dependent) have insurance coverage |
| Employer Phone | with and assign directly to Dr. ///// all insurance benefits, if any, |
| Spouse's Name | 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 |
| | benefits. I authorize the use of this signature on all insurance submissions. I give permission to the doctor to administer treatment and perform such general |
| Spouse's Employer | procedures as he may deem necessary in the diagnosis and / or treatment of my condition. |
| Whom may we thank for referring you? | ny condition. |
| | Responsible Party Signature Date |
| Email? | |
| PHONE NUMBERS | ACCIDENT INFORMATION |
| THONE NOMBERS | ACCIDENTINIORMATION |
| HomeWorkExt | Is condition due to an accident? Yes No Date |
| Best time and place to reach you | Type of accident |
| IN CASE OF EMERGENCY, CONTACT | To whom have you made a report of your accident? |
| Name Relationship | Auto Insurance Employer Worker Comp. Other |
| Home PhoneWork Phone | Attorney Name (if applicable) |
| | |
| | |
| PATIENT CONDITION | |
| Reason for Visit | |
| When did your symptoms appear? | |
| What is your history with this injury? | |
| | |
| The pain is Constant Intermittent — Lasts for min. hrs. days weeks How long have you been having pain? I week or less 1-6 weeks 6 weeks - 3 months 3 months - 1 year > 1 year | |
| | |
| How many times have you had the same type pain in the same area? \Box Never \Box 1-3 episodes \Box 4+ episodes When did you first have those or similar symptoms? \Box Never $\Box < 6$ months area $\Box = 6.12$ months area $\Box < 1$ year area | |
| When did you first have these or similar symptoms? \Box Never $\Box < 6$ months ago \Box 6-12 months ago $\Box > 1$ year ago Activities or movements that are painful to perform: \Box Sitting \Box Standing \Box Bending | |
| Is this condition getting worse? | |
| | |
| Does it interfere with your: Work Sleep Daily Routine Recreation None | |
| - O V E | E R - |