## **CHIROPRACTIC REGISTRATION AND HISTORY**

Date	Who is responsible for this account?
SS/HIC/Patient ID #	Relationship to Patient
Patient Name	Insurance Co.
Last Name	Group #
First Name Middle Initial	Is patient covered by additional insurance? Yes No
ddress	Subscriber's Name
-mail	Birthdate SS#
city	Relationship to Patient
tate Zip	
ex M F Age	Insurance Co.
sirthdate	Group #
☐ Married ☐ Widowed ☐ Single ☐ Minor	ASSIGNMENT AND RELEASE I certify that I, and/or my dependent(s), have insurance coverage with
Separated Divorced Partnered for years	Name of Insurance Company(ies) and assign directly to
atient Employer/School	
ccupation	Dr all insurance benefits, any, otherwise payable to me for services rendered. I understand that I ar
mployer/School Address	financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
	The above-named doctor may use my health care information and may disclos
mployer/School Phone ()	such information to the above-named Insurance Company(ies) and their agent for the purpose of obtaining payment for services and determining insurance
	benefits or the benefits payable for related services. This consent will end whe my current treatment plan is completed or one year from the date signed below.
pouse's Name	
irthdate	Signature of Patient, Parent, Guardian or Personal Representative
S#	Please print name of Patient, Parent, Guardian or Personal Representative
pouse's Employer	riease plint hame of rations, ratent, dualdian of reisonal nepresentative
Vhom may we thank for referring you?	Date Relationship to Patient
PHONE NUMBERS	ACCIDENT INFORMATION
Cell Phone () Home Phone ()	Is condition due to an accident?   Yes   No Date
sest time and place to reach you	Type of accident  Auto Work Home Other
N CASE OF EMERGENCY, CONTACT	To whom have you made a report of your accident?
Name Relationship	Auto Insurance
Home Phone () Work Phone ()	Attorney Name (if applicable)
Home Phone () Work Phone ()	Attorney Name (if applicable)
PATIENT CONDITION	Attorney Name (if applicable)
5 PATIENT CONDITION	
PATIENT CONDITION  Reason for Visit  When did your symptoms appear?  Is this condition getting progressively worse? Yes No Un	known
PATIENT CONDITION  Reason for Visit  When did your symptoms appear?  Is this condition getting progressively worse? Yes No  Mark an X on the picture where you continue to have pain, numbness	known , or tingling.
PATIENT CONDITION  Reason for Visit	known , or tingling.  vere pain)
PATIENT CONDITION  Reason for Visit	known , or tingling.  vere pain)
PATIENT CONDITION  Reason for Visit	known , or tingling.  //ere pain)  Aching Shooting Swelling Other
PATIENT CONDITION  Reason for Visit	known , or tingling.  vere pain)  Aching Shooting Swelling Other
PATIENT CONDITION  Reason for Visit	known , or tingling. //ere pain)    Aching   Shooting   Swelling   Other

HEAL	ТН	HIST	TORY									
What treatment have	ve you al	ready re	ceived for your condi	tion? 🗌 M	1edicatio	ns Surgery	] Physica	al Therap	у	TE SAT		
	Chiroprac	tic Servi	ces None O	ther				27 10 10 10 10 10		7 11 4	25 C = 1	
Name and address	of other	doctor(s	s) who have treated y	ou for you	ır conditi	on						
Date of Last: Phy	sical Exa	ım	Part of the state	Spinal X	-Ray		В	Blood Test				
										20, 100		
	West of a											
Place a mark on "Y	es" or "N	o" to ind	icate if you have had	any of the	e followin	ng:						
AIDS/HIV	Yes	☐ No	Diabetes	Yes	□ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	□ No	
Alcoholism	Yes	☐ No	Emphysema	Yes	☐ No	Measles	☐ Yes	□No	Scarlet Fever	☐ Yes	□ No	
Allergy Shots	Yes	□ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	s 🗌 Yes	☐ No	Sexually Transmitted			
Anemia	Yes	□ No	Fractures	Yes	☐ No	Miscarriage	☐ Yes	☐ No	Disease	☐ Yes	□ No	
Anorexia	Yes	□ No	Glaucoma	Yes	□ No	Mononucleosis	Yes	☐ No	Stroke	☐ Yes	□ No	
Appendicitis	Yes	□ No	Goiter	Yes	□ No	Multiple Sclerosis	Yes	□No	Suicide Attempt	☐ Yes	□ No	
Arthritis	Yes	□ No	Gonorrhea	Yes	□ No	Mumps	Yes	□ No	Thyroid Problems	☐ Yes	□ No	
Asthma	Yes	□ No	Gout	Yes	□ No	Osteoporosis	Yes	□No	Tonsillitis	☐ Yes	□ No	
Bleeding Disorders		□ No	Heart Disease	Yes	□ No	Pacemaker	Yes	□ No	Tuberculosis	☐ Yes	□ No	
Breast Lump	☐ Yes	□ No	Hepatitis	Yes	□ No	Parkinson's Disease		□No	Tumors, Growths	☐ Yes	□ No	
Bronchitis	Yes	□ No	Hernia	Yes	□ No	Pinched Nerve	Yes	□ No	Typhoid Fever	☐ Yes	□ No	
Bulimia	Yes	□ No	Herniated Disk	Yes	□ No	Pneumonia	Yes	□No	Ulcers	☐ Yes	□ No	
Cancer	Yes	□ No	Herpes	Yes	∐No	Polio	Yes	□ No	Vaginal Infections	☐ Yes	□ No	
Cataracts	Yes	☐ No	High Blood Pressure	Yes	□No	Prostate Problem	Yes	□No	Whooping Cough	☐ Yes	□ No	
Chemical Dependency	Yes	□No	High Cholesterol	☐ Yes	□ No	Prosthesis	Yes	□ No	Other	38	1 200	
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	□No	Psychiatric Care Rheumatoid Arthritis	☐ Yes	☐ No	Taking.			
										-		
EXERCISE			WORK ACTIVI	ITY	- 1	HABITS						
None			Sitting		anti- v	☐ Smoking		Pack	s/Day			
Moderate			☐ Standing			Alcohol		Drink	ks/Week			
☐ Daily ☐ Lig			Light Labor			☐ Coffee/Caffeine □	s/Day		- 7			
			☐ Heavy Labor			☐ High Stress Leve	son					
Are you pregnant?	☐ Yes	□No	Due Date									
Injuries/Surgeries you have had				Descr	iption	Date						
Head Injuries			and the second								Taring Control	
	-						MA	1110	MOD TWO	135		
Broken Bones	-	***********										
Dislocations		a d								-0-	affirm i	
Surgeries	¥								100000000000000000000000000000000000000	The State of		
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Pharmacy Name						الزمد و عالم = 4			1.71 1.22 1.28			
Pharmacy Phone (_												