chiropractic registration | health history

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID No. _____

Patient Name _____
First

_____
Middle *Last*

Address _____

_____

City _____ State _____ Zip _____

E-mail _____

Sex: ❍ M ❍ F Age _____

Birth Date _____ SS No. _____

❍ Married ❍ Widowed ❍ Single ❍ Minor

❍ Separated ❍ Divorced ❍ Partnered for ____ years

Patient Employer / School _____

Occupation _____

Employer / School Address _____

Employer / School Phone (____) _____

Spouse's Name _____

Birth Date _____ SS No. _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

INSURANCE INFORMATION

Primary Insurance Co. _____

Group No. _____ ID No. _____

Subscriber's Name _____

Birth Date _____ SS No. _____

Relationship to Patient _____

Is patient covered by secondary insurance? ❍ Yes ❍ No

Secondary Insurance Co. _____

Group No. _____ ID No. _____

Subscriber's Name _____

Birth Date _____ SS No. _____

Relationship to patient _____

ASSIGNMENT AND RELEASE

I certify that I, and / or my dependents(s), have insurance coverage with

_____
Name of Insurance Company(ies)

and assign directly to Dr. Rich 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 authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-name insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of patient, parent, guardian or personal representative

_____
Please print name of patient, parent, guardian or personal representative

_____ _____
Date *Relationship to Patient*

PHONE NUMBERS

Cell Phone _____ Home Phone _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

ACCIDENT INFORMATION

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 ❍ Workers Comp ❍ Other

Attorney name (if applicable) _____

MEDICATIONS

_____

_____

_____

_____

ALLERGIES

_____

_____

_____

_____

VITAMINS / HERBS / MINERALS

_____

_____

Pharmacy Name _____

Pharmacy Phone (_____) _____

[CORE]

embrace prevention | *live* performance

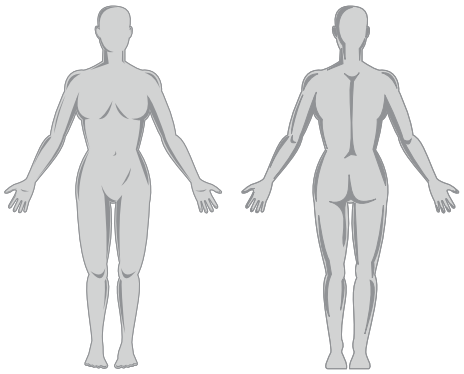
PATIENT CONDITION

Reason for visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ❍ Yes ❍ No ❍ Unknown

Mark an X on the figure to the right 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 ❍ Aching ❍ Numbness ❍ Throbbing

❍ Shooting ❍ Burning ❍ Tingling ❍ Cramps ❍ Stiffness ❍ Swelling ❍ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ❍ Work ❍ Sleep ❍ Recreation ❍ Daily Routine

Activities or movements that are painful to perform: ❍ Sitting ❍ Standing ❍ Walking ❍ Bending ❍ Lying Down

HEALTH HISTORY

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 Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

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	❍ Yes ❍ No	Sexually Transmitted Disease	❍ Yes ❍ No
Anemia	❍ Yes ❍ No	Fractures	❍ Yes ❍ No	Miscarriage	❍ 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	❍ Yes ❍ No	Heart Disease	❍ Yes ❍ No	Pacemaker	❍ Yes ❍ No	Tuberculosis	❍ Yes ❍ No
Breast Lump	❍ Yes ❍ No	Hepatitis	❍ Yes ❍ No	Parkinson's Disease	❍ Yes ❍ 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 _____	
Chicken Pox	❍ Yes ❍ No	Kidney Disease	❍ Yes ❍ No	Psychiatric Care	❍ Yes ❍ No		
				Rheumatoid Arthritis	❍ Yes ❍ No	_____	

EXERCISE

❍ None
❍ Moderate
❍ Daily
❍ Heavy

WORK ACTIVITY

❍ Sitting
❍ Standing
❍ Light Labor
❍ Heavy Labor

HABITS

❍ Smoking Packs/Day _____
❍ Alcohol Drinks/Week _____
❍ Coffee/Caffeine Drinks Cups/Day _____
❍ High Stress Level Reason _____

Are you pregnant? ❍ Yes ❍ No Due Date _____

PREVIOUS INJURIES / SURGERIES:

	Description	*Date*
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		