

# Chiropractic Registration and History

## Patient Information

Date \_\_\_\_\_  
Patient \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
City State Zip  
Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Single  Married  Widowed  Separated  Divorced  
Patient SS# \_\_\_\_\_  
Occupation \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Employer Phone \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Occupation \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
\_\_\_\_\_

## Phone Numbers

Home \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_  
Email \_\_\_\_\_  
Best time and place to reach you \_\_\_\_\_  
**IN CASE OF EMERGENCY, CONTACT:**  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

## Patient Condition

Reason for Visit \_\_\_\_\_  
When did your symptoms appear? \_\_\_\_\_  
Is this condition getting progressively 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  
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

## Insurance

Who is responsible for this account? \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_  
Is patient covered by additional insurance?  Yes  No  
Subscriber's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ 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 \_\_\_\_\_

## 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  Worker Comp.  Other  
Attorney Name (if applicable) \_\_\_\_\_  
\_\_\_\_\_

