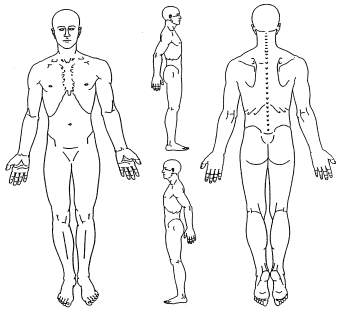
PATIENT REGISTRATION FORM

NAME			HOME #
ADDRESS			WORK #
CITY-STATE-ZIP			DATE OF BIRTH
EMERGENCY CONTACT	PHONE #	SS #	( ) MALE ( ) FEMALE
( )S ( )M ( )D ( )W	ARE YOU PREGNANT? ( ) Y ( ) N	NUMBER AND AGE OF CHILDREN:	DO YOU HAVE HEALTH INSURANCE? ( )YES ( )NO
EMPLOYER		OCCUPATION	
ADDRESS		CITY-STATE-ZIP	
REFERRED BY		PRIVATE PHYSICIAN	

PLEASE INDICATE REGION OF COMPLAINT

- O HEADACHE PAIN
- O NECK PAIN
- O UPPER / MID BACK PAIN
- O LOW BACK PAIN
- O SHOULDER-ELBOW-WRIST-HAND PAIN
- O HIP-KNEE-ANKLE-FOOT PAIN
- O OTHER



USE THE LETTERS LISTED BELOW TO INDICATE THE *TYPE* AND *LOCATION* OF YOUR PAIN AND SENSATIONS...

KEY

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES

MEDICAL HISTORY

	YES	NO	
▪ ARTHRITIC CONDITION	O	O	▪ LIST MEDICATIONS
▪ CANCER	O	O	-
▪ DIABETES	O	O	-
▪ HEART PROBLEMS	O	O	-
▪ HIGH BLOOD PRESSURE	O	O	▪ ALLERGIC TO MEDICATIONS
▪ VASCULAR CONDITION	O	O	-
▪ LUNG PROBLEMS	O	O	-
▪ USUAL CHILDHOOD DISEASES	O	O	▪ ALLERGIES
▪ UNUSUAL CHILDHOOD DISEASES	O	O	-
▪ CURRENTLY PREGNANT	O	O	-
▪ EXERCISE REGULARLY	O	O	▪ HEIGHT
▪ SMOKER	O	O	▪ WEIGHT
▪ ALCOHOL	O	O	▪ LIST SURGERIES / HOSPITALIZATIONS
▪ ALLERGIES	O	O	-
▪ BIRTH CONTROL MEDICATIONS	O	O	-
▪ OTHER			

SPECIFIC INJURY? O YES O NO		DATE OF INJURY
PREVIOUS TREATMENT? O YES O NO		TREATMENT TYPE
DOCTOR NAME		PHONE #
NATURE OF INJURY	O AUTO O WORK RELATED O HOME / OTHER	

SECTION #1 –SYMPTOM QUESTIONAIRE

IS YOUR CONDITION: **( ) GETTING WORSE ( )THE SAME ( ) IMPROVING ( ) OTHER**
PAIN CAME ON: **THE PAIN IS :** **( )GRADUALLY ( )SUDDENLY ( )OCCASIONAL ( ) FREQUENT ( )CONSTANT**
DESCRIBE THE PAIN: **( ) SHARP, LIKE A KNIFE ( )DULL ACHE ( )BURNING SENSATION**
DOES THE PAIN: **( ) STAY IN ONE SPOT ( ) RADIATE ,TRAVEL OR SHOOT ( )GO UP AND DOWN THE SPINE**
IS THE PAIN WORSE IN THE **( ) MORNING ( )AFTERNOON ( )EVENING ( )NIGHT ( ) ALL THE TIME**
WHAT MAKES THE PAIN BETTER?
WHAT MAKES THE PAIN WORSE?
DO YOU HAVE NUMBNESS, TINGLING OR PINS AND NEEDLES IN: ( ) LEGS ( )FEET ( )ARMS ( )HANDS ( )LEFT ( )RIGHT
DOES PAIN AFFECT YOUR SLEEPING? ( )CONSTANTLY ( )FREQUENTLY ( )OCCASIONALLY ( )NO
ANY OTHER SYMPTOMS?
HAVE YOU SEEN A CHIROPRACTOR BEFORE? IF YES, WHO?

SECTION #2 – PERSONAL INJURY

DATE	**TIME** **O AM O PM**	**LOCATION OF ACCIDENT**	
O AUTO V AUTO	**O AUTO V TRUCK**	**O MOTORCYCLE**	**O AUTO V BUS**
O AUTO V PEDESTRIAN	**O SLIP & FALL**	**O OTHER**	
PLEASE DESCRIBE INJURY			
O DRIVER OR O PASSENGER	**O FRONT SEAT OR O BACK SEAT**	**WEARING SEAT BELT OR SHOULDER HARNESS?**	**O YES O NO**
BODY PARTS STRUCK	**O YES O NO**	**IF YES, PLEASE LIST**	
EMERGENCY TREATMENT?	**O YES O NO**	**IF YES, WHERE?**	
WORK –RELATED?	**O YES O NO**	**IF YES, ANY WORK LOSS?**	**O YES O NO**
LOSS OF CONSCIOUSNESS?	**O YES O NO**	**WERE YOU BLEEDING?**	**O YES O NO**
X –RAY TAKEN?	**O YES O NO**	**IF YES, LIST AREAS**	

AUTHORIZATION TO RELEASE MEDICAL INFORMATION / FINANCIAL AGREEMENT

I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION REQUESTED BY MY INSURANCE COMPANY TO DOCUMENT MY CLAIM FOR BENEFITS. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR FULL PAYMENT OF ALL CHARGES FOR MY TREATMENT. SERVICES ARE PAYABLE AT THE TIME RENDERED.

_____ _____

PATIENT OR GUARDIAN SIGNATURE **DATE**