CHIROPRACTIC REGISTRATION & HEALTH HISTORY

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____

_____

Address _____

_____

City _____

State _____ Zip _____

Email _____

Cell Phone # _____

Sex □ Male □ Female Age _____

Birthdate _____

□ Married □ Widowed □ Single □ Minor

□ Separated □ Divorced □ Partnered for _____ years

Occupation _____

Employer/School _____

Employer/School Address _____

_____

Employer/School Phone _____

Spouse Name _____

Birthdate _____

Spouse's Employer _____

How did you learn about us? _____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

PRIMARY INSURANCE

Insurance Co. _____

Member ID # _____

Group # _____

SECONDARY INSURANCE (if any)

Insurance Co. _____

Member ID # _____

Group # _____

ASSIGNMENT & RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with {INSURANCE CO} and assign directly to Dr. James C. Gardner, DC 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.

Dr. Gardner may use my health care information and may disclose such information to the above-named 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

_____

Print Name

_____

Date Relationship to Patient

EMERGENCY CONTACT

Name _____

Relationship to Patient _____

Phone # _____

ACCIDENT INFORMATION

Is this condition due to an accident? □ Yes □ No Date _____

Type of accident □ Auto □ Work □ Home □ Other

Accident reported to □ Auto Ins □ Employer □ Work □ Other

Attorney Name (if applicable) _____

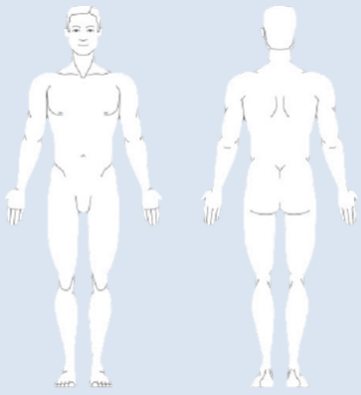
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? _____

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 severe) to 10 (severe pain) _____

Type of pain:

How often do you have this pain? _____

Is it constant or does in come and go? _____

Does it interfere with your

Activities or movements that are painful to perform

Health Questionnaire

Please check mark each of the conditions that you are currently experiencing.

Musculo-Skeletal System

- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Broken bones
- ☐ Shoulder pain

Genito-Urinary System

- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

Are you pregnant?

- ☐ Yes
- ☐ No

Female

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on the breast

Gastro-Intestinal System

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting blood
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble

Cardio-Vascular

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficult breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

Nervous System

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscle jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

Eye, Ear, Nose, & Throat

- ☐ Eye strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Difficult breathing through nose
- ☐ Sore gums
- ☐ Dental problems
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Sinus
- ☐ Allergy
- ☐ Jaw pain

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavily

WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light labor
- ☐ Heavy Labor

HABITS

- ☐ Cigarettes — Pack/Day _____
- ☐ Alcohol abuse — Drinks/Week _____
- ☐ Coffee or tea — Cups/Day _____
- ☐ High stress level — Reason _____
- ☐ _____

INJUJRIES/SURGERIES	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLEGIES	VITAMINS/HERBS/MINERALS