CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

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

_____ and assign directly to
Name of Insurance Company(ies)

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 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-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

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 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) _____

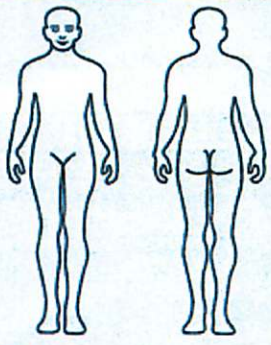
5 PATIENT CONDITION

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

6 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	Stroke ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Bleeding Disorders ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tumors, Growths ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Parkinson's Disease ☐ Yes ☐ No	Typhoid Fever ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Vaginal Infections ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Whooping Cough ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	Other _____
Chemical Dependency ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Prosthesis ☐ Yes ☐ No	
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 _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

AFC CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

NAME: _____DATE: _____
ADDRESS _____
HOME PHONE: _____ CELL PHONE: _____
WHICH PHONE WOULD YOU LIKE TO BE CALLED FOR REMINDER CALLS: _____
DO YOU HAVE NEW INSURANCE? (**CIRCLE ONE**) YES NO

What are the concerns for which you are seeking care? (Primary concern first)
1._____ Date of onset: _____
2._____ Date of onset: _____
3._____ Date of onset: _____
4._____Date of onset: _____

MEDICATIONS AND SUPPLEMENTS

What medications (prescribed or over the counter), herbs, vitamins, supplements, etc. are you currently taking?

_____
_____
_____

Check each that you currently use:

[ ] Laxatives	[ ] Pain relievers	[ ] Antacids	[ ] Cortisone
[ ] Antibiotics	[ ] Heart/Blood medication	[ ] Allergy Medication	[ ] Thyroid Medication
[ ] Sleeping pills	[ ] Anti-depressants	[ ] Birth Control Pills	[ ] Hormones

Indicate if there have been any of the following diseases in you, your parents, grandparents, brothers, sisters or children. Indicate the number of relatives who have the disease.

Cancer _____	Diabetes_____	Epilepsy_____
Heart Disease_____	High Blood Pressure_____	Stroke_____
Anemia_____	Kidney Disease_____	Glaucoma_____
Allergies_____	Asthma_____	Mental Illness_____
Arthritis_____	Tuberculosis_____	Alzheimer's Disease_____

Have you had any immunizations? (Circle one) Yes No Negative Reactions? _____

HOSPITALIZATIONS, SURGERY, X-RAY AND SPECIAL STUDIES

What hospitalizations, surgeries, x-rays, or special studies have you had?

_____ Year: _____	_____ Year: _____
_____ Year: _____	_____ Year: _____
_____ Year: _____	_____ Year: _____
_____ Year: _____	_____ Year: _____
_____ Year: _____	_____ Year: _____

AFC CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Are you hypersensitive or allergic to latex or any medications? Please list:

_____

_____

General

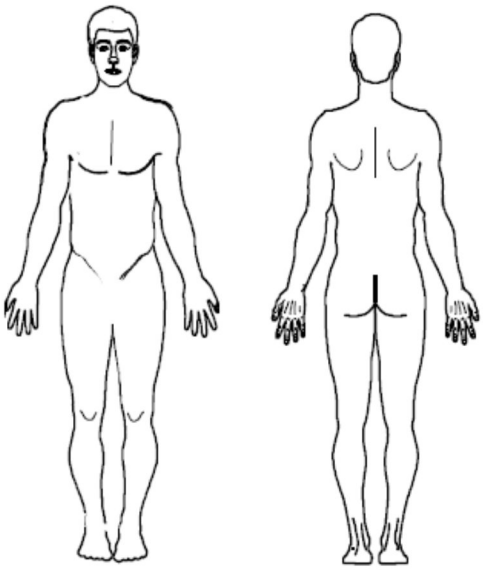
Weight _____lbs. Height _____

Blood Pressure _____ Pulse_____

Right or Left handed? _____

Review of Symptoms

Please mark an X in areas where you are experiencing pain on figures (if applicable).



LIFESTYLE HABITS

Answer questions of the following you have or have had in the past 6 months.

How often do you exercise? _____

What kind of exercise? _____

Major traumas? _____

Drink coffee? _____

Drink Black or green tea? _____

Drink Cola or other sodas? _____

Use alcoholic beverages? _____ # per week _____

Use tobacco currently? _____

Used tobacco in the past? _____ How many years? _____ How many packs per day? _____

AFC REVIEW OF SYMPTOMS

Name: _____ Date: _____

Check any of the following you have or have had in the past 6 months.

Headache

___Vertigo
___Dizziness
___Nausea
___Light Sensitivity
___Vomiting
___ Aura
___ TMJ
___ Migraine
Other: _____
Severity:
___Mild
___Moderate
___Severe
Frequency:
___Constant
___ Intermittent
Number of days _____
___No Change
___ Re-occurring
___ New

Neck Pain

___Right Side
___Left Side
___Burning
___Numbness
___Tingling
___ Dull
___ Sharp
___ Shooting
Other: _____
Severity:
___Mild
___Moderate
___Severe
Frequency:
___Constant
___ Intermittent
Radiating? _____
What were you doing?
_____
___No Change
___ Re-occurring
___ New

Mid-Back

___Upper mid-back
___Lower mid-back
___Burning
___Numbness
___Tingling
___ Dull
___ Sharp
___ Shooting
Other: _____
Severity:
___Mild
___Moderate
___Severe
Frequency:
___Constant
___ Intermittent
Radiating? _____
What were you doing?
_____
___No Change
___ Re-occurring
___ New

Low back

___Burning
___Numbness
___Tingling
___ Dull
___ Sharp
___ Shooting
Other: _____
Severity:
___Mild
___Moderate
___Severe
Frequency:
___Constant
___ Intermittent
Radiating? _____
What were you doing?
_____
___No Change
___ Re-occurring
___ New

Extremities

___Left arm
___Right arm
___ Left leg
___ Right leg
___ Left hand
___ Right hand
___ Left foot
___ Right foot
___Burning
___Numbness
___Tingling
___ Dull
___ Sharp
___ Shooting
Other: _____
Severity:
___Mild
___Moderate
___Severe
Frequency:
___Constant
___ Intermittent
Radiating? _____
What were you doing?
_____
___No Change
___ Re-occurring
___ New

Skin

___ Rashes
___Eczema, Hives
___ Acne, Boils
___ Itching
___ Fungal Infections
___ Color change
___ Hair Loss
___ Dry Skin/ scalp
___ Lumps
___ Night sweats
___Slow healing ulcerations
____ Flushing or hot flashes

AFC REVIEW OF SYMPTOMS

Name: _____ Date: _____

Check any of the following you have or have had in the past 6 months.

Nose and Sinuses
___ Frequent colds
___ Nose bleeds
___ Stuffiness
___ Hay fever
___ Sinus problems
___ Loss of smell

Eyes and Ears
___Itchy eyes
___ Watery eyes
___ Dry eyes
___ Swollen/painful eyes
___ Red eyes
___ Impaired vision/ blurriness
___Floaters in vision
___ Cataracts
___ Color blindness
___ Double vision
___ Glaucoma
___ Hearing difficulty
___ Ringing
___ Earaches/infection

Mouth and Throat
___ Sore Throat
___ Teeth grinding
___ Sore tongue/ lips
___ Gum problems
___ Hoarseness
___ Difficulty swallowing

Respiratory
___ Chest congestion
___ Wheezing
___ Asthma
___ Bronchitis/Pneumonia
___ Emphysema
___ Difficulty/Pain breathing
___ Shortness of breath
___ Tuberculosis
___Cough ___wet or ___dry
___ Coughing blood

Cardiovascular
___Heart disease
___ Angina/Chest pain
___ High/Low blood pressure
___Murmurs
___ Irregular heart beat
___ Palpitations/fluttering
___ Swelling in ankles

Circulation
___ Easy bleeding or bruising
___ Anemia
___ Deep leg pain
___ Varicose veins
___ Cold hands/ feet

Endocrine
___ Hypothyroid
___ Heat or cold intolerance
___ Hypoglycemia
___ Diabetes
___ Excessive thirst
___ Excessive hunger
___ Fatigue
___ Seasonal depression

Immune
___ Chronic fatigue syndrome
___ Chronic infections
___ Chronically swollen glands
___ Slow wound healing

Muscles/ Joints/ Bones
___ Joint pain
___ Muscle pain
___ Muscle spasms/ cramps
___ Restless leg syndrome
___ Sciatica
___ Osteoporosis

Neurologic
___Seizures
___ Paralysis
___ Muscle weakness
___ Numbness or tingling
___ Easily stressed
___ Vertigo or dizziness
___ Loss of balance
___ Tics

Digestion
___ Trouble swallowing
___ Heartburn / Acid Reflux
___ Change in thirst/ appetite
___ Ulcer
___ Nausea/vomiting
___ Gas/ bloating
___ Belching or passing gas
___ Diarrhea
___ Constipation
___ Pain or cramps
___ Mucous in stools
___ Black/ bloody stool
___ Hemorrhoids
___ Itchy/ burning anus
___ Rectal pain
___ Liver/ gall bladder trouble
___ Jaundice (Yellow skin)
Bowel Movements: How often? _____

Urinary
___ Pain on urination
___ Increased frequency
___ Frequency at night
___ Frequent infections
___ Inability to hold urine
___ Kidney stones
___ Blood in urine

AFC REVIEW OF SYMPTOMS

Name: _____ Date: _____

Check any of the following you have or have had in the past 6 months.

Mental/ Emotional

___ Mood swings
___ Anxiety or nervousness
___ Considered/ Attempted suicide
___ Depression
___ Poor concentration
___ Poor memory
___ Other: _____

General

___ Poor sleep/ insomnia
___ Dream disturbed sleep
___ Fatigue/ low energy
___ General feel hot
___ General feel cold
___ Chills
___ Fevers
___ Poor appetite
___ Constant hunger
___ Cravings _____
___ Peculiar taste in mouth
___ Low libido
___ Experience high stress

Male only

___ Hernias
___ Testicular masses
___ Testicular pain
___ Prostate disease
___ Sexually transmitted disease

Female Only

___ Irregular cycles
___ Bleeding between cycles
___ Pain during intercourse
___ Clotting
___ Heavy or excessive flow
___ PMS
___ Endometriosis
___ Difficulty conceiving
___ Painful menses
___ Ovarian cysts
___ Menopausal symptoms
___ Abnormal PAP
___ Sexually transmitted disease
___ Breast pain/ tenderness
___ Nipple discharge
___ Breast lumps
Birth Control? _____
Type: _____
Number of pregnancies _____
# of Boys: _____
# of Girls: _____
Could you be pregnant now? _____