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 ___________________ Hone 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

MEDICATIONS	ALLERGIES	VITAMINS / HERBS / MINERALS
________________	________________	________________________
________________	________________	________________________
________________	________________	
________________	________________	

Pharmacy Name ___________________________________

Pharmacy Phone (_____) ___________________________________

[CORE]

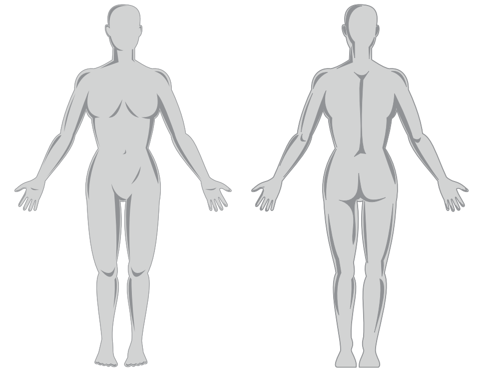
embrace prevention | *live* performance

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:

Condition		Condition		Condition		Condition	
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 ______________________

PREVIOUS INJURIES / SURGERIES:

Description *Date*

Falls ____

Head Injuries ____

Broken Bones ____

Dislocations ____

Surgeries ____