CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient_____

Patient Social Security #_____

Address_____

_____

City State Zip

Email_____

Sex: □ M □ F Age_____ Birth Date_____

□ Single □ Married □ Widowed □ Separated □ Divorced

Occupation_____

Employer_____

Spouse's Name_____

Birthdate_____Occupation_____

Whom may we thank for referring you?_____

2 PAYMENT INFORMATION

__Auto Insurance Claim __Commercial Insurance

__No Insurance (Self Pay) __Medicare

__Worker's Compensation

If this is a Commercial Insurance Claim, please fill out the following "Assignment and Release" and provide your health insurance card to the receptionist so she can make a copy of the card. We will file the insurance claim for you.

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependant) have insurance coverage with _____and assign directly to Stine Chiropractic Clinic 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

3 PHONE NUMBERS

Home_____ Work_____ Ext._____

Cell_____ Best number to reach you_____

May we remind you of your next appointment via text msg?

Yes No (Circle One) If yes, what carrier?_____

IN CASE OF EMERGENCY, CONTACT

Name_____Relationship_____

Phone_____Alt Ph_____

4 ACCIDENT INFORMATION

Is condition due to an accident? __Y __N Date_____

Type of accident __Auto __Work __Home __Other

To whom have you made a report of your accident?

__Auto Ins __Employer __Work Comp. __Other

Information for Auto Claims Only:

Name of Auto Insurance:_____

Claim #_____Ph #_____

Adjuster's Name:_____

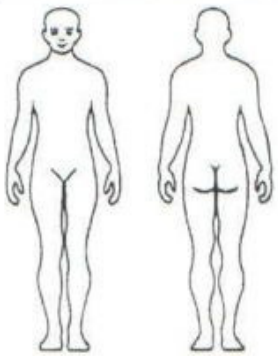
5 PATIENT CONDITION

Reason for Visit_____

When did you symptoms appear?_____

Is this condition getting progressively worse? □ Yes □ No __Unknown

Mark and X on the picture for pain and mark // for numbness and/or tingling.



Please Rate the Severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

Pain Rating for Past 24 hrs: _____ Pain Rating for the Past Week: _____

Type of Pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other

How often do you have this pain? □ Constant □ Frequently (50-75% of the day)

□ Occasionally (25-50% of the day) □ Intermittently (under 25% of the day)

Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation

Activities or movements that are painful to perform: □ Sitting □ Standing □ Walking □ Bending □ Lying Down

In general, would you say that your overall health is: □ Excellent □ Very Good □ Good □ Fair □ Poor

Patient Signature X_____ Date_____

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therpay ☐ Chiropractic Services ☐ None ☐ other_____

Name and addres of others doctor(s) who have treated your condition_____

Date of last: Physcial Exam_____ Spinal X-Ray_____ Blood Test_____
Spinal Exam_____ Chest X-Ray_____ Urine Test_____
Dental X-Ray_____ MRI, CT Scan, Bone Scan_____

Please place a mark to indicate if you have had any of the following:

☐ AIDS/HIV	☐ Emphysema	☐ Migraine Headaches	☐ Rheumatic Fever
☐ Alcoholism	☐ Epilepsy	☐ Miscarriage	☐ Scarlet Fever
☐ Allergy Shots	☐ Fractures	☐ Mononucleosis	☐ Stroke
☐ Anemia	☐ Glaucoma	☐ Multiple Sclerosis	☐ Suicide Attempt
☐ Appendicitis	☐ Goiter	☐ Mumps	☐ Thyroid Problem
☐ Arthritis	☐ Gout	☐ Osteoporosis	☐ Tonsillitis
☐ Asthma	☐ Heart Disease	☐ Pacemaker	☐ Tuberculosis
☐ Bleeding Disorders	☐ Hepatitis	☐ Parkinson's Disease	☐ Tumors/Growths
☐ Breast Lump	☐ Hernia	☐ Pinched Nerve	☐ Typhoid Fever
☐ Bronchitis	☐ Herniated Disk	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ High Cholesterol	☐ Prostate Problem	Whooping Cough
☐ Chemical Dependency	☐ Kidney Disease	☐ Prosthesis	O Other_____
☐ Chicken Pox	☐ Liver Disease	☐ Psychiatric Care	_____
☐ Diabetes	☐ Measles	☐ Rheumatoid Arthritis	

EXERCISE	**Work Activity**	**Habits**
☐ None	☐ Sitting	☐ Smoking *Packs/Day*_____
☐ Moderate	☐ Standing	☐ Alcohol *Drinks/Week*_____
☐ Daily	☐ Light Labor	☐ Coffee/Caffiene *Drinks/Week*_____
☐ Heavy	☐ Heavy Labor	☐ 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_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

People choose chiropractic care for a number of reasons. How long you decide to benefits from chiropractic care is always up to you. Please check the type of care you desire so that we can meet your needs whenever possible.
___Relief Care ___Corrective Care ___Maintenance Care ___Check here if you'd like the Doctor to decide the best type for you

By my signature below , I authorize the Stine Chiropractic Clinic to release any information deemed appropriate to any doctor, insurance company or attorney in the course of my treatment or in order to process any claim for reimbursement of charges. I hereby assign all the right, title and interest relative to insurance benefits to the Stine Chiropractic Clinic. I clearly understand and agree that I am personally responsible for payment of all services rendered to me. Further, in the event that my account is turned over for collection, I understand that I will be responsible for any charges, attorney fees, collection costs and court cost incurred in collecting the balance.

By my signature below, I acknowledge that there are inherent risks involved with spinal manipulation. In 1995, Rand reported the risk of serious complication approximate 1 in 1 million to 1 in 1.5 million. I authorize the doctor to diagnose and treat my condition as deemed appropriate, including the use of spinal manipulation. I understand the above information and guarantee that this form was completed correctly to the best of my knowledge.

SIGNATURE_____ **DATE**_____

IF MINORS, PARENT/GUARDIAN SIGNATURE_____ **DATE**_____