# REGISTRATION

Name: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell #: _____ Work #: _____ Home #: _____

Occupation: _____ Age: _____ Birthday: _____ Marital Status: M S D W

Spouse's Name: _____ # Children _____

Whom may we thank for referring you? _____

## HEALTH INFORMATION

Have you had previous chiropractic care? □ Yes □ No

Main Complaint: _____

_____

Other Complaint: _____

_____

How long have you had this condition? _____

Does this condition affect your work? _____

What aggravates this condition? _____

_____

What helps your symptoms? _____

_____

Other Doctors seen for this condition: _____

_____

Are you currently taking any medication? □ Yes □ No If yes, please list:

_____

Have you had any surgeries, falls, or accidents? □ Yes □ No

When? _____ Please describe: _____

_____

Is this condition due to:

A work related injury? □ Yes □ No An automobile accident? □ Yes □ No

** If you answer **Yes** to either of the above question, Please inform us before proceeding.

## SYMPTOM CHECK LIST

| | YES | NO |
|---|---|---|
| Abdominal Pain | □ | □ |
| Anemia | □ | □ |
| Arm or Shoulder Pain | □ | □ |
| Back Pain | □ | □ |
| Bladder Problem | □ | □ |
| Bowel Problem | □ | □ |
| Chest Pain | □ | □ |
| Circulatory Problem | □ | □ |
| Depression | □ | □ |
| Diabetes | □ | □ |
| Dizziness | □ | □ |
| Fatigue | □ | □ |
| Headache | □ | □ |
| Heart Problem | □ | □ |
| High/Low Blood Pressure | □ | □ |
| Hot Flashes | □ | □ |
| Insomnia | □ | □ |
| Joint Pain | □ | □ |
| Kidney Problem | □ | □ |
| Lung/Bronchial Problem | □ | □ |
| Memory Problem | □ | □ |
| Menstrual Problem | □ | □ |
| Neck Pain | □ | □ |
| Numbness | □ | □ |
| Psychiatric Problem | □ | □ |
| Sinus Problem | □ | □ |
| _____ | □ | □ |

**INSURANCE**

Who is responsible for this account? _____

Relationship to patient: _____ SS#: _____

Insurance company _____Group #: _____

Is Patient covered by additional insurance? □ YES □ NO

Subscriber's name _____

Relationship to patient: _____ SS#: _____

Insurance company _____ Group #: _____

**Complete only for:**

**JOB INJURY INFORMATION**

Date of Injury: _____ Time: _____ Location: _____

Description of accident: _____

_____

_____

Worker Compensation Case #: _____

Adjuster's Name: _____ Phone #: _____

Insurance Company's Name: _____

Address: _____

Employer's Name: _____

Address: _____

Hospitalized? □ Yes □ No Name of Hospital _____ X-Rays Taken? □ Yes □ No

Other Doctors Seen: _____ Phone #: _____

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I understand and agree that health and accident insurance policies are arrangement between an insurance carrier and myself. Furthermore, I understand that my Doctor will prepare any necessary reports and forms to assist me in obtaining payment from the insurance company and that any amount authorized will be paid directly to my Doctor and be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____