

# Chiropractic Registration & History

## 1 PATIENT INFORMATION

Date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex ( ) M ( ) F Age \_\_\_\_\_ Birth Date \_\_\_\_\_

( ) Single ( ) Married Widowed ( ) Divorced ( )

Patient SS # \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Spouse Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse Employer \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Or how did you hear about us?

( ) Yellow Pages ( ) Internet

( ) Yellow Book ( ) Doctor/Surgeon

( ) Friend/Family ( ) Attorney

( ) Drive By ( ) Other \_\_\_\_\_

## 2 INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to the patient \_\_\_\_\_

If you are not the main card holder, we must have

Subscriber's name \_\_\_\_\_

Birth Date \_\_\_\_\_ SS \_\_\_\_\_

**Please present your card to the front desk so we can make a copy.**

### ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or the dependent) have insurance coverage with \_\_\_\_\_ and assign directly to **Action Chiropractic Inc.** 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 \_\_\_\_\_

Mobile \_\_\_\_\_ E-Mail \_\_\_\_\_

**In Case of Emergency**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_

Mobile \_\_\_\_\_

## 4 ACCIDENT INFORMATION

Is this condition due to an accident? ( ) Yes ( ) No

Type of accident ( ) Auto ( ) Work ( ) Home ( ) Other

Date of accident \_\_\_\_\_

To whom have you reported the accident?

( ) Auto Insurance ( ) Employer ( ) Workers Comp

Attorney Name & Number if (applicable) \_\_\_\_\_

## 5 PATIENT CONDITION

Reason for your Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition Getting Worse ( ) Yes ( ) No ( ) Unknown

**Mark on the diagram where your symptoms are located.**

Rate the severity of your symptoms on a pain scale of 1 (Least) to 10 (Severe) \_\_\_\_\_

Type of pain: ( ) Sharp ( ) Dull ( ) Throbbing ( ) Numbness ( ) Aching ( ) Shooting  
( ) Burning ( ) Tingling ( ) Cramps ( ) Swelling ( ) Stiffness

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with: ( ) Work ( ) Sleep ( ) Daily Routine ( ) Recreation

Activities or movement that are painful to perform: ( ) Sitting ( ) Standing  
( ) Walking ( ) Bending ( ) Laying Down ( ) Coughing/Sneezing



