## **CHIROPRACTIC REGISTRATION AND HISTORY**

Date		Who is responsible for thi	s account?			
SS/HIC/Patient ID #						
Patient Name		Insurance Co.				
Last Name						
First Name	Middle Initial		itional insurance? ☐ Yes ☐ No			
Address			monarmsurance:   Tes   No			
E-mail			SS#			
City						
State Zip						
Sex 🗌 M 🔲 F Age						
Birthdate						
☐ Married ☐ Widowed ☐ Single	☐ Minor	ASSIGNMENT AND RELEAS I certify that I, and/or my	SE y dependent(s), have insurance coverage with			
☐ Separated ☐ Divorced ☐ Partnere	ed for years	Name of Insurance	and assign directly to			
Patient Employer/School						
Occupation			all insurance benefits, i ne for services rendered. I understand that I am			
Employer/School Address		financially responsible for all of the use of my signature on all	charges whether or not paid by insurance. I authorize I insurance submissions.			
		The above-named doctor ma	y use my health care information and may disclose			
Employer/School Phone ()		for the purpose of obtaining	e-named Insurance Company(ies) and their agents payment for services and determining insurance			
Spouse's Name			ble for related services. This consent will end when completed or one year from the date signed below.			
Birthdate						
		Signature of Patient, F	Parent, Guardian or Personal Representative			
SS#		Disease wint name of Datio				
Paguaga Employer		Please pillit name or rane	nt, Parent, Guardian or Personal Representative			
		Date	Relationship to Patient			
Whom may we thank for referring you?		Date				
Whom may we thank for referring you?  PHONE NUMBERS		ACCIDEN				
PHONE NUMBERS  Cell Phone () Home Pho	one ()	ACCIDEN	T INFORMATION  dent?  Yes  No Date			
PHONE NUMBERS  Cell Phone () Home Pho	one ()	ACCIDEN Is condition due to an accid	TINFORMATION  dent?			
PHONE NUMBERS  Cell Phone () Home Phosest time and place to reach you  N CASE OF EMERGENCY, CONTACT	one ()	ACCIDEN  Is condition due to an accident ☐ Auto ☐  To whom have you made a	TINFORMATION  dent?			
PHONE NUMBERS  PHONE NUMBERS  Cell Phone () Home Phosest time and place to reach you  N CASE OF EMERGENCY, CONTACT  Name Relationsh	one ()	Is condition due to an accident Auto To whom have you made a Auto Insurance Emp	dent?  Yes No Date Other report of your accident? Other Worker Comp. Other			
PHONE NUMBERS  Cell Phone () Home Pho  Best time and place to reach you IN CASE OF EMERGENCY, CONTACT  Name Relationsh  Home Phone () Work Phone	one () nip ne ()	Is condition due to an accident Auto To whom have you made a Auto Insurance Emp	dent?  Yes No Date Other report of your accident? Other Other Other Other Other Other			
PHONE NUMBERS  Cell Phone () Home Pho Best time and place to reach you IN CASE OF EMERGENCY, CONTACT  Name Relationsh	one () nip ne ()	Is condition due to an accident Auto To whom have you made a Auto Insurance Emp	dent?			
PHONE NUMBERS  Cell Phone () Home Pho Best time and place to reach you N CASE OF EMERGENCY, CONTACT  Name Relationsh Home Phone () Work Phone	one () nip ne ()	ACCIDEN  Is condition due to an accident  Auto  Type of accident  Auto  To whom have you made a  Auto Insurance  Emp	dent?  Yes No Date Other report of your accident? Other Other Other Other Other Other			
PHONE NUMBERS  Cell Phone () Home Pho Best time and place to reach you IN CASE OF EMERGENCY, CONTACT  Name Relationsh Home Phone () Work Phone	one ()	Is condition due to an accident  Auto  To whom have you made a  Auto Insurance  Emp	dent?			
PHONE NUMBERS  Cell Phone () Home Pho Best time and place to reach you N CASE OF EMERGENCY, CONTACT  Name Relationsh Home Phone () Work Phone  PATIENT CONDITION  Reason for Visit When did your symptoms appear? Is this condition getting progressively worse?	one ()  nip  ne () <b>D N</b> □ Yes □ No □ Unk	ACCIDEN  Is condition due to an accident  Auto  To whom have you made a  Auto Insurance  Emp  Attorney Name (if applicable)	dent?			
PHONE NUMBERS  Cell Phone () Home Pho Best time and place to reach you IN CASE OF EMERGENCY, CONTACT  Name Relationsh  Home Phone () Work Phone  PATIENT CONDITION  Reason for Visit  When did your symptoms appear? Is this condition getting progressively worse? Mark an X on the picture where you continue	one () nip ne ()_  O N  Yes No Unk to have pain, numbness,	ACCIDEN  Is condition due to an accident  Auto  Type of accident  Auto  To whom have you made a  Auto Insurance  Emp  Attorney Name (if applicable anown or tingling.	dent?  Yes No Date Other report of your accident? Other Other Other Other Other Other			
Cell Phone () Home Phone Best time and place to reach you IN CASE OF EMERGENCY, CONTACT  Name Relationsh  Home Phone () Work Phone  PATIENT CONDITION  Reason for Visit  When did your symptoms appear? Is this condition getting progressively worse?  Mark an X on the picture where you continue  Rate the severity of your pain on a scale from	one ()	ACCIDEN  Is condition due to an accident  Auto  Type of accident  Auto  To whom have you made a  Auto Insurance  Emp  Attorney Name (if applicable anown or tingling.	dent? Yes No Date Work Home Other report of your accident?			
PHONE NUMBERS  Cell Phone () Home Pho Best time and place to reach you IN CASE OF EMERGENCY, CONTACT  Name Relationsh  Home Phone () Work Phone  PATIENT CONDITION  Reason for Visit When did your symptoms appear? Is this condition getting progressively worse? Mark an X on the picture where you continue  Rate the severity of your pain on a scale from Type of pain: Sharp Dull Thr	one ()  nip ne ()  ON  Yes No Unk to have pain, numbness, n 1 (least pain) to 10 (seve	ACCIDEN  Is condition due to an accident  Auto  Type of accident  Auto  To whom have you made a  Auto Insurance  Emp  Attorney Name (if applicable applicable accident  Auto Insurance  Autorney Name (if applicable applicable applicable accident  Autorney Name (if applicable applicable applicable applicable applicable accident  Autorney Name (if applicable applic	dent?			
PHONE NUMBERS  Cell Phone () Home Phone PATIENT CONDITION Reason for Visit Work Phone	one () nip ne ()  O N  Yes  No  unk to have pain, numbness, n 1 (least pain) to 10 (seve	ACCIDEN  Is condition due to an accident  Auto  Type of accident  Auto  To whom have you made a  Auto Insurance  Emp  Attorney Name (if applicable applicable accident  Auto Insurance  Autorney Name (if applicable applicable accident  Autorney Name (if	dent?			

Name and address of oth Date of Last: Physical Expendency Dental X-Place a mark on "Yes" or AIDS/HIV YAIcoholism YAIDS/HIV Allergy Shots YAIDS Anemia YAIDS Arthritis YAIDS Bleeding Disorders YAIDS Breast Lump YAIDS Bronchitis YAIDS Bulimia YAIDS Cancer YAIDS Chemical Dependency	ractic Servi mer doctor(s  Exam  Ray  "No" to ind fes  No	ces None Of	ou for you Spinal X Chest X MRI, CT any of the	-RayRayRayRayRayRay	on	B U V Yes	lood Test		Yes	
Name and address of oth Date of Last: Physical Expendency Dental X-Place a mark on "Yes" or AIDS/HIV YAIcoholism YAIDS/HIV Allergy Shots YAIDS Anemia YAIDS Arthritis YAIDS Bleeding Disorders YAIDS Breast Lump YAIDS Bronchitis YAIDS Bulimia YAIDS Cancer YAIDS Chemical Dependency	mer doctor(s  Exam  Am  Ray  "No" to ind  les No  les	icate if you have had Diabetes Emphysema Epilepsy Fractures Glaucoma Goiter Gonorrhea Gout Heart Disease Hepatitis Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol	ou for you Spinal X Chest X MRI, CT any of the Yes Yes Yes Yes Yes Yes Yes Yes Yes Ye	-RayRayRayRayRayRollowing No	one Scang: Liver Disease Measles Migraine Headaches Miscarriage Mononucleosis Multiple Sclerosis Mumps Osteoporosis Pacemaker Parkinson's Disease Pinched Nerve Pneumonia	B Ves Yes Yes Yes Yes Yes Yes Yes Yes Yes Y	lood Test rine Test No No No No No No No No	Rheumatic Fever Scarlet Fever Sexually Transmitted Disease Stroke Suicide Attempt Thyroid Problems Tonsillitis Tuberculosis	Yes	No
Date of Last: Physical Expinal Example Place a mark on "Yes" or AIDS/HIV YAICOHOLISM YAICOHOLISMA YAICOH	Exam	icate if you have had Diabetes Emphysema Epilepsy Fractures Glaucoma Goiter Gonorrhea Gout Heart Disease Hepatitis Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol	Spinal X Chest X MRI, CT any of the Yes Yes Yes Yes Yes Yes Yes Yes Yes Ye	-RayRayScan, B -Scan, B	cone Scan	Yes	No	Rheumatic Fever Scarlet Fever Sexually Transmitted Disease Stroke Suicide Attempt Thyroid Problems Tonsillitis Tuberculosis	Yes	No
Spinal Examples on "Yes" or AIDS/HIV	Ray	icate if you have had Diabetes Emphysema Epilepsy Fractures Glaucoma Goiter Gonorrhea Gout Heart Disease Hepatitis Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol	Chest X.  MRI, CT any of the  Yes Yes Yes Yes Yes Yes Yes Yes Yes Y	-RayScan, B - followin     No	g: Liver Disease Measles Migraine Headaches Miscarriage Mononucleosis Multiple Sclerosis Mumps Osteoporosis Pacemaker Parkinson's Disease Pinched Nerve Pneumonia	Yes	No	Rheumatic Fever Scarlet Fever Sexually Transmitted Disease Stroke Suicide Attempt Thyroid Problems Tonsillitis Tuberculosis	Yes	No
Dental X- Place a mark on "Yes" or AIDS/HIV	Ray  "No" to ind fes No	icate if you have had Diabetes Emphysema Epilepsy Fractures Glaucoma Goiter Gonorrhea Gout Heart Disease Hepatitis Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol	MRI, CT	Scan, Be following No	g: Liver Disease Measles Migraine Headaches Miscarriage Mononucleosis Multiple Sclerosis Mumps Osteoporosis Pacemaker Parkinson's Disease Pinched Nerve Pneumonia	Yes   Yes	No	Rheumatic Fever Scarlet Fever Sexually Transmitted Disease Stroke Suicide Attempt Thyroid Problems Tonsillitis Tuberculosis	Yes	No
Dental X- Place a mark on "Yes" or AIDS/HIV	Ray  "No" to ind fes No	icate if you have had Diabetes Emphysema Epilepsy Fractures Glaucoma Goiter Gonorrhea Gout Heart Disease Hepatitis Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol	MRI, CT	Scan, Be following No	g: Liver Disease Measles Migraine Headaches Miscarriage Mononucleosis Multiple Sclerosis Mumps Osteoporosis Pacemaker Parkinson's Disease Pinched Nerve Pneumonia	Yes   Yes	No	Rheumatic Fever Scarlet Fever Sexually Transmitted Disease Stroke Suicide Attempt Thyroid Problems Tonsillitis Tuberculosis	Yes	No
Place a mark on "Yes" or AIDS/HIV	"No" to ind  ses No	Diabetes Emphysema Epilepsy Fractures Glaucoma Goiter Gonorrhea Gout Heart Disease Hepatitis Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol	any of the	Following No	g: Liver Disease Measles Migraine Headaches Miscarriage Mononucleosis Multiple Sclerosis Mumps Osteoporosis Pacemaker Parkinson's Disease Pinched Nerve Pneumonia	Yes   Yes	No	Rheumatic Fever Scarlet Fever Sexually Transmitted Disease Stroke Suicide Attempt Thyroid Problems Tonsillitis Tuberculosis	☐ Yes	<ul><li>□ No</li><li>□ No</li><li>□ No</li><li>□ No</li><li>□ No</li><li>□ No</li></ul>
AIDS/HIV	No   No   No   No   No   No   No   No	Diabetes Emphysema Epilepsy Fractures Glaucoma Goiter Gonorrhea Gout Heart Disease Hepatitis Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol	<ul> <li>Yes</li> </ul>	No	Liver Disease Measles Migraine Headaches Miscarriage Mononucleosis Multiple Sclerosis Mumps Osteoporosis Pacemaker Parkinson's Disease Pinched Nerve Pneumonia	Yes   Yes	No	Scarlet Fever Sexually Transmitted Disease Stroke Suicide Attempt Thyroid Problems Tonsillitis Tuberculosis	☐ Yes	□ No
Alcoholism	No   No   No   No   No   No   No   No	Emphysema Epilepsy Fractures Glaucoma Goiter Gonorrhea Gout Heart Disease Hepatitis Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol	<ul> <li>Yes</li> </ul>	No	Measles Migraine Headaches Miscarriage Mononucleosis Multiple Sclerosis Mumps Osteoporosis Pacemaker Parkinson's Disease Pinched Nerve Pneumonia	Yes   Yes	No	Scarlet Fever Sexually Transmitted Disease Stroke Suicide Attempt Thyroid Problems Tonsillitis Tuberculosis	☐ Yes	<ul><li>□ No</li><li>□ No</li><li>□ No</li><li>□ No</li><li>□ No</li><li>□ No</li></ul>
Allergy Shots	No   No   No   No   No   No   No   No	Epilepsy Fractures Glaucoma Goiter Gonorrhea Gout Heart Disease Hepatitis Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol	<ul> <li>Yes</li> </ul>	No	Migraine Headaches Miscarriage Mononucleosis Multiple Sclerosis Mumps Osteoporosis Pacemaker Parkinson's Disease Pinched Nerve Pneumonia	Yes   Yes	No	Sexually Transmitted Disease Stroke Suicide Attempt Thyroid Problems Tonsillitis Tuberculosis	☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	No
Anemia	No   res   No   No   res   No   No   res   R	Fractures Glaucoma Goiter Gonorrhea Gout Heart Disease Hepatitis Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol	<ul> <li>Yes</li> </ul>	No   No   No   No   No   No   No   No	Miscarriage Mononucleosis Multiple Sclerosis Mumps Osteoporosis Pacemaker Parkinson's Disease Pinched Nerve Pneumonia	Yes   Yes	No	Transmitted Disease Stroke Suicide Attempt Thyroid Problems Tonsillitis Tuberculosis	☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	□ No
Anorexia	No   No   No   No   No   No   No   No	Glaucoma Goiter Gonorrhea Gout Heart Disease Hepatitis Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol	☐ Yes	<ul> <li>No</li> </ul>	Mononucleosis Multiple Sclerosis Mumps Osteoporosis Pacemaker Parkinson's Disease Pinched Nerve Pneumonia	☐ Yes	No	Stroke Suicide Attempt Thyroid Problems Tonsillitis Tuberculosis	☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	□ No
Appendicitis   Yi Arthritis   Yi Asthma   Yi Bleeding Disorders   Yi Breast Lump   Yi Bronchitis   Yi Bulimia   Yi Cancer   Yi Cataracts   Yi Chemical   Dependency   Yi Chicken Pox   Yi EXERCISE   None   Moderate   Daily   Heavy  Are you pregnant?   Yi Injuries/Surgeries you ha	fes	Goiter Gonorrhea Gout Heart Disease Hepatitis Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol	☐ Yes	<ul><li>No</li><li>No</li><li>No</li><li>No</li><li>No</li><li>No</li><li>No</li><li>No</li><li>No</li><li>No</li></ul>	Multiple Sclerosis Mumps Osteoporosis Pacemaker Parkinson's Disease Pinched Nerve Pneumonia	☐ Yes	<ul><li>No</li><li>No</li><li>No</li><li>No</li><li>No</li><li>No</li></ul>	Suicide Attempt Thyroid Problems Tonsillitis Tuberculosis	☐ Yes ☐ Yes ☐ Yes	
Arthritis	No   No   No   No   No   No   No   No	Gonorrhea Gout Heart Disease Hepatitis Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol	☐ Yes	<ul><li>No</li><li>No</li><li>No</li><li>No</li><li>No</li><li>No</li><li>No</li><li>No</li><li>No</li></ul>	Mumps Osteoporosis Pacemaker Parkinson's Disease Pinched Nerve Pneumonia	Yes Yes Yes Yes Yes Yes	No No No No No	Thyroid Problems Tonsillitis Tuberculosis	☐ Yes	□ No
Asthma	fes No	Gout Heart Disease Hepatitis Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol	☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes	<ul><li>No</li><li>No</li><li>No</li><li>No</li><li>No</li><li>No</li><li>No</li></ul>	Osteoporosis Pacemaker Parkinson's Disease Pinched Nerve Pneumonia	Yes Yes Yes Yes	□ No □ No □ No	Tonsillitis Tuberculosis	Yes	uES
Bleeding Disorders   Yi Breast Lump   Yi Bronchitis   Yi Bulimia   Yi Cancer   Yi Cataracts   Yi Chemical   Dependency   Yi Chicken Pox   Yi EXERCISE   None   Moderate   Daily   Heavy  Are you pregnant?   Yi Injuries/Surgeries you ha	/es	Heart Disease Hepatitis Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol	☐ Yes	No No No No	Pacemaker Parkinson's Disease Pinched Nerve Pneumonia	☐ Yes ☐ Yes ☐ Yes ☐ Yes	□ No	Tuberculosis	-	□ No
Breast Lump	res No	Hepatitis Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol	☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	☐ No☐ No☐ No☐ No☐	Parkinson's Disease Pinched Nerve Pneumonia	Yes	□ No			
Bronchitis	res □ No	Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol	☐ Yes☐ Yes☐ Yes☐ Yes	☐ No	Pinched Nerve Pneumonia	☐ Yes		Tumora Croutha	Yes	□ No
Bulimia	res No res No res No res No	Herniated Disk Herpes High Blood Pressure High Cholesterol	☐ Yes	☐ No	Pneumonia		☐ 140		☐ Yes	□ No
Cancer YOCancer YOCancer YOCancer YOCataracts YOChemical Dependency YOCANCEXERCISE None Moderate Daily Heavy  Are you pregnant? YOCANCE YOCANCE YOCANCE YOCANCE YOCANCE YOCANCE YOCANCE YOU Pregnant? YOU Pregnant? YOCANCE YOU Pregnant? YOU Pregnant	es □ No es □ No	Herpes High Blood Pressure High Cholesterol	Yes			L les	□No	Typhoid Fever	☐ Yes	□ No
Cataracts	es □ No	High Blood Pressure High Cholesterol				Yes	□ No	Ulcers	Yes	□ No
Chemical Dependency Y Chicken Pox Y EXERCISE None Moderate Daily Heavy Are you pregnant? Y njuries/Surgeries you ha	es □ No	Pressure High Cholesterol	☐ Yes		Prostate Problem	☐ Yes	□ No	Vaginal Infections	Yes	□ N
Dependency				☐ No	Prosthesis	☐ Yes	□ No	Whooping Cough	Yes	□ No
EXERCISE  None  Moderate  Daily  Heavy  Are you pregnant? Ye	es 🗌 No	Kidney Disease	☐ Yes	□No	Psychiatric Care	☐ Yes	□ No	Other		
☐ None ☐ Moderate ☐ Daily ☐ Heavy  Are you pregnant? ☐ You		Mulley Disease	☐ Yes	☐ No	Rheumatoid Arthritis					
<ul><li>None</li><li>Moderate</li><li>Daily</li><li>Heavy</li></ul> Are you pregnant?		WORK ACTIVI	ITV		HABITS					
☐ Moderate ☐ Daily ☐ Heavy  Are you pregnant? ☐ You		☐ Sitting	111		☐ Smoking		Packs	s/Day		
☐ Daily ☐ Heavy  Are you pregnant? ☐ You	Cre - 1	☐ Standing			☐ Alcohol			s/Week		
Heavy  Are you pregnant? Your pregnant? Your pregnant?			and the second		Coffee/Caffeine Drinks Cups/Day					
Are you pregnant? You	☐ Heavy ☐ Heavy Labor									
njuries/Surgeries you ha				☐ High Stress Level R				eason		
		Due Date	Descr					Date		
Falls				Date:						
Head Injuries			C 10 7						Egar	
Broken Bones				7,1						
Dislocations		2.72.55								
Surgeries									1434	
										Lu.
MEDIO	CATIC	NC	T ,	ATTE	RGIES	VITA	MITNI	S/HERBS/M	INF	AI
MEDI	CAIIU	MO	A	1 L L L	NUIES	VIIF	Z IVI I IV	S/IIENDS/W	LIVER	AL
				ننيب						
Pharmacy Name										
Pharmacy Name Pharmacy Phone (										-