CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date: ____________________

Social Security #: ____________________

Patient Name: ____________________
Last name

____
First Name Middle Initial

Address: ____________________

City: __________ State: _______ Zip: _________

Email: ____________________

Sex: ☐ M ☐ F Birthdate: ______________ Age: ________

☐ Single ☐ Married Minor ☐ Wid- ☐ owed

☐ Divorced ☐ Partnered ☐ Separated

Occupation: ____________________

Employer/School: ____________________

Employer Phone: ____________________

Employer Address: ____________________

____

Spouse's Name: ____________________

Spouse's Employer: ____________________

How did you hear about us?

____

3 INSURANCE INFORMATION

Are you covered under insurance? ☐ Yes ☐ No

If so, please fill out the following; if not, leave blank

Insurance Company: ____________________

Member/Policy #: ____________________

Is patient covered by additional insurance? ☐ Yes ☐ No

ASSIGNMENT AND RELEASE

I Certify that I, and/or my dependent(s), have insurance coverage with

____
Name of Insurance Company(ies)

and assign directly to **DR. BAYS** 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-named 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

2 PHONE NUMBERS

Cell ______________ Home ______________

Best time/place to reach you? ____________________

EMERGENCY CONTACT

Name: ____________________

Relationship ______________ Cell: ______________

Home: ______________ Work: ______________

4 ACCIDENT INFORMATION

Is this condition due to an accident: ☐ No ☐ Yes, Date: ________

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Insurance ☐ Employer ☐ Workman's Comp. ☐ Other

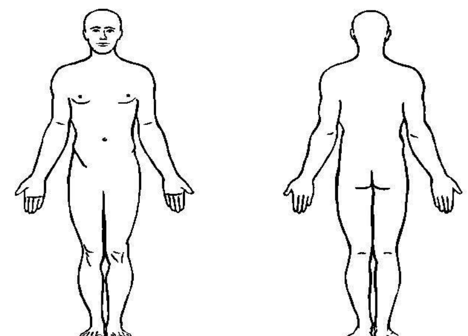
Attorney Name (if applicable) ____________________

Phone Number: ____________________

5 PATIENT CONDITION

Reason for visit: ____________________

Mark an X on the picture where you are experiencing pain:



Date when symptoms appeared: ____________________

Is the condition progressively worse? ☐ Yes ☐ No ☐ Unknown

Rate the severity of pain from a 1 (least pain) to 10 (severe pain): _______

Type of Pain: ☐ Sharp ☐ Dull ☐ Tingling ☐ Numbness ☐ Throbbing ☐ Burning ☐ Cramps ☐ Stiff ☐ Swelling ☐ Shooting ☐ Aching

How often do you have this pain: ☐ First Time ☐ Re-occurring

Is the pain: ☐ Constant ☐ Intermittent (come and go)

Does the pain interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Standing ☐ Sitting ☐ Walking ☐ Bending ☐ Laying Down ☐ Other

6

HEALTH HISTORY

What treatments have you received for this condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ None ☐ Other

Primary Care Physician: ______________________ **Previous Chiropractic Care:** ______________________

Address: ______________________ Address: ______________________

Date of last: Physical Exam:______________ Blood Test:__________ Spinal X-Ray:__________

Spinal Exam:______________ Urine Test:__________ Chest X-Ray:__________

MRI/CT Scan/Bone Scan: ______________ Dental X-Ray:__________

Are you currently pregnant? ☐ No ☐ Yes, Due Date:

Please mark if you have had any of the following conditions:

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

Daily Routine Exercise	Physical Work Activity	Habits	
☐ None	☐ Sitting	☐ Tobacco	Pack per day:__________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks a week:__________
☐ Heavy	☐ Light Labor	☐ Caffeinated Drinks	Cups a day:__________
Describe Exercise:	☐ Moderate Labor	☐ High Stress Level	Reason:__________
	☐ Heavy Labor		

Please list any injuries you have had:	Date they occurred:
Broken Bones:	
Surgeries:	
Dislocations:	
Serious Falls:	
Head Injuries:	
Other:	

Please list medications and their dosages	Allergies	Vitamins/Supplements