Midtown Chiropractic Patient Registration and History

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip Code

Sex ☐ Male ☐ Female Age ____ Birth date _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient S.S.# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birth Date _____

Occupation _____

Spouse's Employer _____

How did you hear about us? _____

Your E-mail: _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____ Employer _____

Is patient covered by additional insurance? ☐Yes ☐ No

Subscriber's Name _____

Birth Date _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____ Employer _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Midtown Chiropractic all insurance benefits, if any, otherwise payable to me for all 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 _____

Cell Phone _____

In case of emergency, contact

Name _____ Relationship _____

Phone _____ Alt. phone _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

5 PATIENT CONDITION

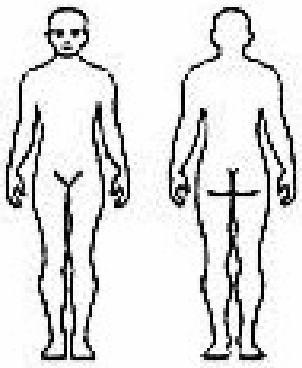
Reason for visit _____

When did your symptoms appear? _____

Dates of similar symptoms _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Please mark an "X" on the picture above where you continue to have pain, numbness, or tingling



Rate the severity of your condition on a scale of 1(mild)-10(very severe) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant, or does it come and go? _____

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

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

6 HEALTH HISTORY

What treatments have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other _____

Name and contact information for other doctor(s) who have treated your condition _____

Date of Last:					
	Physical Exam		Spinal X-ray		Blood Test	
	Spinal Exam		Chest X-ray		Urine Test	
	Dental X-ray		MRI, CT-Scan, Bone Scan			

Place a mark on the "Yes" to indicate if you have had any of the following:

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

Exercise	**Work Activity**	**Habits**	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day _____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason _____

Are you pregnant? ☐Yes ☐ No If **Yes**, Due Date _____

Injury/Surgeries you have had:	Description	Dates
Falls:		
Head Injuries:		
Broken Bones:		
Dislocations:		
Surgeries:		

7

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy name:		
Pharmacy phone:		