Chiropractic Registration and History

1 PATIENT INFORMATION

Date_____

Patient_____

Address_____

City_____State_____Zip_____

Sex:◯M◯F Age_____Birthdate_____

Patient SS # _____

Occupation_____Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Occupation_____

Who may we thank for referring you?_____

2 INSURANCE

Is the primary insured your spouse? Yes◯ No◯

If yes, Name of spouse_____

Spouse's Birthdate_____

Spouse's SS#_____

Spouse's Employer_____

ASSIGNMENT AND RELEASE

I authorize payment directly to this office of the group insurance benefits otherwise payable to me. Verification of insurance benefits may not guarantee insurance payment to this office therefore, I understand that I am responsible for all costs of chiropractic treatment. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1.5% a month. Patients who permanently discontinue care plan will be required to pay off any account balance within 10 days. I hereby authorize Dr. Flynn and 96th Street Chiropractic, LLC staff to administer and perform such diagnostic and therapeutic procedures as may be necessary for proper care. Original x-rays will remain the property of 96th Street Chiropractic, LLC. I have read and agree to the Financial Policies and Disclosure of Fees of 96th Street Chiropractic.

_____ _____

Responsible Party Signature Date

3 PHONE NUMBERS

Home_____

Mobile _____

Work_____

Email address_____

EMERGENCY CONTACT

Name_____Relationship_____

Best Phone #'s to contact_____

_____

4 ACCIDENT INFORMATION

Is this condition due to an accident? ◯YES ◯NO

Date of accident_____

◯Auto ◯Work ◯Home ◯Other

OVER ⇨

5 HEALTH HISTORY

Are you pregnant? __Yes __No Due Date: _____

What treatment have you already received for your condition? __Medications __Surgery __Physical Therapy
__Chiropractic Services __None __Other _____

Name of other doctor(s) who have treated you for your condition _____

Please circle any of the following you have experienced:

Allergies	Arthritis	Asthma	Cancer	Concentration Loss	Concussion
Depression	Diabetes	Digestive Problems	Dizziness	Earache	Fractures
HIV	Heart Attack	Heart Disease	Hepatitis	Herniated Disk	High BP
Hypertension	Insomnia	Memory Loss	Migraine	Pacemaker	Sinus Trouble
Stroke	Ulcers				

Any prior hospitalization, surgery, or broken bones? _____

PRESENT COMPLAINTS - Please circle any of the following you are currently experiencing:

Dizziness	Upper Back Pain/Stiffness	Right/Left Leg Pain	Swelling (_____)
Neck Pain	Midback Pain/Stiffness	Right/Left Arm Pain	Numbness (_____)
Headaches	Low Back Pain/Stiffness	Pins & Needles Arms/Legs	Other _____
Loss of Balance	Chest Pain	Knee Pain	

Other health conditions we should know: _____
_____

Are you currently being treated by a physician? __ Yes __ No

If Yes, for what? _____
_____

EXERCISE
__ None __ Moderate
__ Daily __ Heavy

WORK ACTIVITY
__ Sitting __ Standing
__ Light Labor __ Heavy Labor

HABITS
__ Smoking Packs/Day _____
__ Alcohol Drinks/Week _____
__ Coffee/Caffeine Cups/Day _____
__ High Stress Level Reason _____

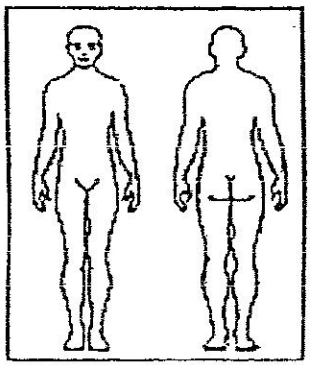
6 PATIENT CONDITION

What is your primary complaint(s)? _____

When did your symptoms appear? _____

Is this condition getting progressively worse? __Yes __No __Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____

Type of pain: __Sharp __Dull __Throbbing __Numbness __Aching __Shooting
__Burning __Tingling __Cramps __Stiffness __Swelling __Other

How often do you have this pain? __Occasionally __Intermediate __Frequent __Constant

Does this interfere with your __Work __Sleep __Daily Routine __Recreation

Activities or movements that are painful to perform __Sitting __Standing __Walking __Bending __Lying Down