

PATIENT REGISTRATION

Please Print. All information will be kept confidential

Last Name _____ First _____ Middle _____ Today's Date _____
Address _____ City _____ State _____ Zip _____

Social Security# ____/____/____ Age ____ Birth Date _____ Sex ____ Marital Status ____ # of children ____
Home Phone _____
Work Phone _____
Employer _____ Address _____ Phone _____
Occupation _____ Drivers License # _____ State _____ Expiration Date _____

E-Mail Address: _____

How were you referred to our office? _____

Have you ever had Chiropractic care before? _____ If YES when? _____

List your chief complaints in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____

List the other doctors you have consulted for this condition: _____

Are you covered under any other group or individual health policy through yourself or spouse? _____

Address _____ Company _____

Spouse's Social Security # _____ Spouse's Employer _____

Is this injury or illness work-related? _____ Have you reported it to your employer? _____

Is this injury related to an automobile accident? _____

Do you have an attorney that has advised you in this case? _____ If YES, whom _____ Telephone # _____

Name & phone # of someone not living with you to contact in case of Emergency _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT OR ILLNESS:

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head Seems Heavy | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Pins&Needles in Arms | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Pins&Needles in Legs | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Neuritis |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Constipation | <input type="checkbox"/> Digestive Disorder |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Shortness of Breath Fainting | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |

Any other symptoms and/or remarks: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will immediately be due and payable.

Patient's Signature _____ Date _____