

# Chiropractic Registration and History

## Patient Information

Date \_\_\_\_\_

Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_

Last Name

First Name

Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_

Birth Date \_\_\_\_\_

Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Birth Date \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Phone Numbers

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Alt. Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Alt. Phone ( \_\_\_\_\_ ) \_\_\_\_\_

## Patient Condition

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

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

Rate the severity of your pain on a scale from 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? \_\_\_\_\_

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

## Insurance

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birth Date \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

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

\_\_\_\_\_ and assign directly to  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ 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

## Accident Information

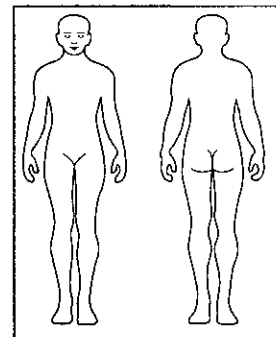
Is condition due to an accident?  Yes  No Date \_\_\_\_\_

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) \_\_\_\_\_



# Health History

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy

Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for 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 \_\_\_\_\_

Mark box "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please mark in each column which boxes best describe your activities:

## EXERCISE

- None
- Moderate
- Daily
- Heavy

## WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

## HABITS

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Packs/Day \_\_\_\_\_

Drinks/Week \_\_\_\_\_

Cups/Day \_\_\_\_\_

Reason \_\_\_\_\_

Are you pregnant?  Yes  No

Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

## Medications

## Allergies

## Vitamins/Herbs/Minerals

_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy Name \_\_\_\_\_

Pharmacy Phone (\_\_\_\_) \_\_\_\_\_

Pharmacy E-mail (\_\_\_\_) \_\_\_\_\_



JOHN D. SMITH, D.C.

609 E. Centre St.  
Portage, MI 49002  
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### TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxation or neuro-musculoskeletal conditions. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation. However, we may use other procedures to help your body hold the adjustments.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

#### Consent to evaluate and adjust a minor child

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_  
\_\_\_\_\_ have read and fully understand the above terms of acceptance  
and hereby grant permission for my child to receive chiropractic care.

Smith Chiropractic  
John D. Smith, D.C.  
609 E. Centre St.  
Portage, MI 49002  
269.329.1660

## Notice of Privacy Policy

As required by HIPAA, our office has implemented a policy to protect the privacy of our patients. A copy of that policy is available to you at any time upon request.

Please place a '✓' or 'x' in the appropriate space below:

\_\_\_\_\_ I have RECEIVED a copy of the privacy policy for Smith Chiropractic.

OR

\_\_\_\_\_ I DECLINE to receive a copy of the privacy policy for Smith Chiropractic.

Please PRINT patient name: \_\_\_\_\_

SIGNATURE of patient or parent/guardian if patient is under the 18 years of age:

X \_\_\_\_\_ Date: \_\_\_\_\_