REGISTRATION INFORMATION

(Please Print)

Date__________________ Home Phone______________________________

Patient____
Last Name First Name Initial (Maiden)

Street Address____
City____________________________ State______________ Zip____________

Sex ☐M ☐F Age _______ Birthdate________ ☐ Single ☐ Married ☐ Separated ☐ Divorced

☐ Employed ☐ Full-time Student ☐ Part-time Student Patient's School__________________________

Patient Employed by____

Business Address____

Occupation________________________________Business Phone_____________________

Spouse (or responsible party) Name ______________________________ Birthdate _______________

Business Name and Address____

Occupation _____________________________________ Business Phone_______________________

Who is responsible for this account? ☐ Self ☐ Parent ☐ Legal Guardian Name_________________

Address____
City State Zip

Social Security #______________________ Spouse's Social Security #_______________________

Do you have Medical Insurance? ☐ No ☐ Yes

Name of Primary Insurer____

Contract #_______________Group #_______________Subscriber #_______________

Name of Secondary Insurer (if any)____

Contract #_______________Group #_______________Subscriber #_______________

Are you covered under any of these programs?
☐ Medicare ☐Medicaid ☐CHAMPUS ☐CHAMPVA ☐ Workers Compensation ☐FECA Black Lung

ID # for the program you've checked____

If Welfare, your number______________________________County of___________________

Is your condition related to employment (current or previous) ☐ No ☐ Yes

Is your condition related to an auto accident? ☐ No ☐ Yes In which state?____________________

Other accident? ☐ No ☐ Yes Please describe ______________________________________

In case of an emergency, who should be notified? ______________________________________

Phone__________________________ Relationship to patient_______________________________

REGISTRATION INFORMATION

(Please Print)

Please list other doctors you have seen in the past 5 years:

1. ______________________________ City/State ______________________________
(General Practitioner, Specialist, Other)

Reason for seeing______________________________

2. ______________________________ City/State ______________________________
(General Practitioner, Specialist, Other)

Reason for seeing______________________________

How did you learn of our practice?______________________________

Whom may we thank for referring you?______________________________

ASSIGNMENT AND RELEASE

I undersigned, have insurance with ______________________________
Name of Insurance Company

And assign directly to **PREFERRED CHIROPRACTIC** all medical benefits, if any, otherwise payable to me for services Rendered. Understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize The release of all information necessary to secure the payment of benefits. I authorize the use of the signature on all my Insurance submissions whether manual or electronic.

______________________________ ______________________________
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **PREFERRED CHIROPRACTIC** for any services furnished me by that office. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information need to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________________ ______________________________
Beneficiary Signature Date

PATIENT HE TH QUESTIONNAIRE

NAME________________________ DATE ___/___/___ (MONTH DAY YEAR)

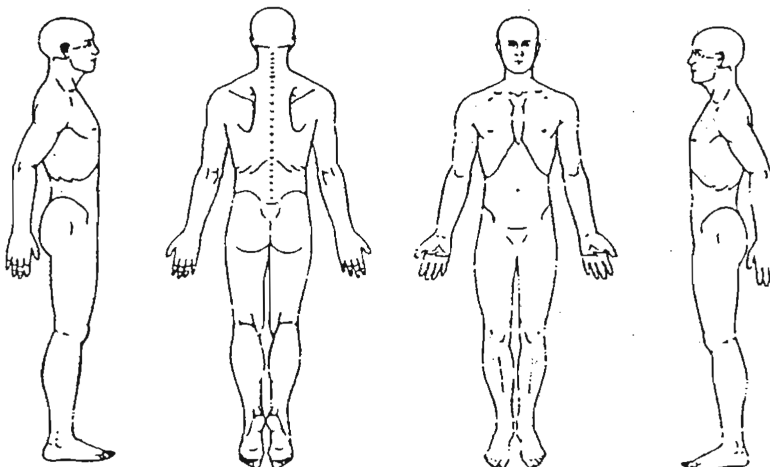
In the space below, please describe your major complaint.
If you have an additional complaint, please describe on page 3.

1. Please Describe Your Complaint: ______________________________

____

____

a. Description:	**b. Frequency:**
☐ Sharp Pain	☐ Constant (76-100%)
☐ Dull Pain	☐ Frequent (51-75%)
☐ Ache	☐ Occasional (26-50%)
☐ Weak	☐ Intermittent (25%or less)
☐ Throbbing	
☐ Numb	
☐ Shooting	**MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.**
☐ Gripping	
☐ Burning	
☐ Tingling	



c. Indicate intensity of your pain at its lowest and highest level No Pain [0] [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] Unbearable Pain

d. Your symptoms are ☐ decreasing ☐ not changing ☐ increasing

e. Symptoms are worse in the ☐ Morning ☐ Afternoon ☐ Night ☐ Increases during the day ☐ Same all day.

2. When did your problem begin: SPECIFIC DATE IF POSSIBLE? ______________ Describe how your problem began: ______________

____

____

3. Have you been treated ***for this episode***? ☐ Yes ☐ No
   If yes, by whom? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other ______________
   Are you currently being seen? ☐ Yes ☐ No
   When and what treatment? ___/___/___ ______________________________

   ____

4. ***In the past*** have you been treated for the same or a similar problem? ☐ Yes ☐ No
   If yes, who did you see for that episode? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other ______________
   When and what treatment did you receive? ______________________________

   ____

5. What makes your problem better? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity
6. What makes your problem worse? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity
7. How would you rate your general stress level? ☐ Little or No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed
8. General Physical Activity: ☐ No regular exercise program ☐ Light exercise program ☐ Moderate exercise program ☐ Strenuous exercise program
9. Are your complaints affecting your ability to be active?
   ☐ No effect
   ☐ Some physical restrictions (able to perform light duty work and houshold tasks).
   ☐ Need limited assistance with common everyday tasks.
   ☐ Need assistance often.
   ☐ Have a significant inability to function without assistance.
   ☐ Am totally disabled (impaired). Cannot care for self.
10. Physical activity at work: ☐ Sitting more than 50% of workday ☐ Light manual labor ☐ Manual labor ☐ Heavy manual labor ☐ Repeated motion
11. Occupation: ______________________ ☐ FT ☐ PT Has your work status changed because of this complaint? ☐ YES ☐ NO
12. What is your current work status?
    [1] Full time, no restrictions.
    [2] Full time, with restrictions.
    [3] Part time, no restrictions.
    [4] Part time, with restrictions.
    [5] Off work due to restrictions.
    [6] Full time homemaker.
    [7] Unemployed.
    [8] Retired.
    [9] Full time student.
    [10] Other: ______________

PLEASE CONTINUE ON PAGE 2

Patient's Signature: ______________________________ Date: ___/___/___

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If you have ever had a listed condition in the past, please check it in the Past column. If you are presently troubled by a particular condition, check it in the Present column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

PATIENT HEALTH QUESTIONNAIRE

Past	Present	
☐	☐	Neck Pain (723.1)
☐	☐	Shoulder Pain (719.41)
☐	☐	Pain in Upper Arm or Elbow (719.42)
☐	☐	Hand Pain (719.44)
☐	☐	Wrist Pain (719.43)
☐	☐	Upper Back Pain (724.1)
☐	☐	Low Back Pain (724.2)
☐	☐	Pain in Upper Leg or Hip (719.45)
☐	☐	Pain in Lower Leg or Knee (729.5)
☐	☐	Pain in Ankle or Foot (719.47)
☐	☐	Jaw Pain (526.9)
☐	☐	Swelling/Stiffness of Joint(s)
☐	☐	Fainting (780.2)
☐	☐	Visual Disturbances (368.9)
☐	☐	Convulsions (780.3)
☐	☐	Dizziness (780.4)
☐	☐	Headache (784.0)
☐	☐	Muscular Incoordination (781.3)
☐	☐	Tinnitus (Ear Noises) (388.30)
☐	☐	Rapid Heart Beat (785.0)
☐	☐	Chest Pains (786.50)
☐	☐	Loss of Appetite (783.0)
☐	☐	Anorexia (307.1)
☐	☐	Abnormal Weight ☐ Gain (783.1) ☐ Loss (783.2)
☐	☐	Excessive Thirst (783.5)
☐	☐	Chronic Cough (786.2)
☐	☐	Chronic Sinusitis (473.9)
☐	☐	General Fatigue (780.7)
☐	☐	Irregular Menstrual Flow (626.4)
☐	☐	Profuse Menstrual Flow (626.7)
☐	☐	Breast Soreness/Lumps (611.72)
☐	☐	Endometriosis (617.9)
☐	☐	PMS (625.4)
☐	☐	Loss of Bladder Control (788.30)
☐	☐	Painful Urination (788.1)
☐	☐	Frequent Urination (788.41)
☐	☐	Abdominal Pain (789.0)
☐	☐	Constipation/irregular bowel habits (564.0)
☐	☐	Difficulty in Swallowing (787.2)
☐	☐	Heartburn/Indigestion (787.1)
☐	☐	Dermatitis/Eczema/Rash (692.9)
☐	☐	Depression (311)

Past	Present	
☐	☐	Aortic Aneurysm (441.5)
☐	☐	High Blood Pressure (401.9)
☐	☐	Angina (413.9)
☐	☐	Heart Attack (410.9)
☐	☐	Stroke (436)
☐	☐	Asthma (493.9)
☐	☐	Cancer (199.1)
☐	☐	Tumor (229.9)
☐	☐	Prostate Problems (601.9)
☐	☐	Blood Disorder (790.6)
☐	☐	Emphysema (chronic lung disorders) (492.8)
☐	☐	Arthritis (716.9)
☐	☐	Rheumatoid Arthritis (714.0)
☐	☐	Diabetes (250.0)
☐	☐	Epilepsy (349.5)
☐	☐	Ulcer (556.9)
☐	☐	Liver (573.9) / Gallbladder (575.9) problems
☐	☐	Kidney Stones (592.0)
☐	☐	Hepatitis (573.3)
☐	☐	Bladder Infection (595.9)
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis (558.9)
☐	☐	Irritable Colon (564.1)
☐	☐	HIV/AIDS (042)
☐	☐	Systemic Lupus
☐	☐	Other________________

If a family member has had any of the following please mark the appropriate box:

☐ Cancer	☐ Epilepsy
☐ Rheumatoid Arthritis	☐ Chronic Back Problems
☐ Diabetes	☐ Chronic Headaches
☐ Heart Problems	☐ Lupus
☐ Lung Problems	☐ Other Conditions ____________
☐ High Blood Pressure	____________

Yes	No	
☐	☐	Do you have a permanent disability rating?
☐	☐	Location ____________
☐	☐	Date rating received ___/___/___
		Rating Percentage _______%

Please check any of the following that apply to you.

Past	Present	
☐	☐	Pregnancy (V22.2)
☐	☐	Birth Control Pills
☐	☐	Hormonal/Estrogen Replacement
☐	☐	Medications (list if not listed elsewhere) ____________ ____________
☐	☐	Hospitalization/Surgical Procedures (list if not described elsewhere) ____________ ____________

Past	Present	
☐	☐	Tobacco (305.1)
☐	☐	Alcohol (305.0)
☐	☐	Drug or Alcohol Dependence (303.9)
☐	☐	Coffee/Tea/Caffeinated Soft drinks: cups/cans per day____________ ____________

Present: Weight ______ pounds **Height** ____ feet _____ inches

Patient's signature: ______________________________ **Date:** ____/____/____

Doctor's Additional Comments/General Health Concerns:

____

____

____

____

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