REGISTRATION AND HISTORY

Patient Information

Date _____
SSN _____
Name _____
Address _____
City _____
State _____ **Zip** _____
E-mail _____
Sex M F **Age** _____
Birthdate _____
Married Widowed Single Minor (please circle)
Separated Divorced Partnered
Occupation _____
Patient Employer/School _____
Employer/School Address _____
_____
Employer/School Phone _____
Spouse/Partner's Name _____
Birthdate _____
SSN _____
Spouse/Partner's Employer _____
Whom may we thank for referring you? _____

Phone Numbers

Home Phone _____ Work/Cell Phone _____
Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT
Name _____ Relationship _____
Home Phone _____ Alternate Phone _____

Insurance

Who is responsible for this account? _____
_____
Relationship to patient _____
Insurance Co. _____
ID# _____
Group # _____
Is there additional insurance coverage? _____

Assignment and Release

I certify that I, and/or my dependents have insurance coverage with _____ and assign directly to Dr. _____ 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 my insurance company. 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 and their agents for the purpose of obtaining payment and determining benefits.

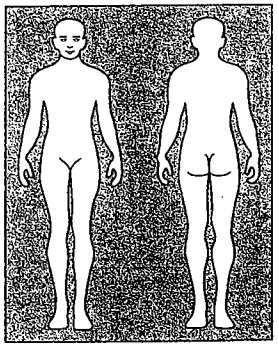
Signature: _____
Print Name: _____
Date: **Relationship:** _____

Accident Information

Is this condition due to an accident? Yes No
Date _____
Type of Accident: Auto Work Home Other
To whom have you reported accident to?
Auto Insurance Employer Work.Comp. Other
Attorney's Name: _____

Patient Condition

Reason for visit: _____
When did your symptoms appear? _____
Is this condition getting progressively worse? _____
Mark an X on the picture where you are having symptoms →
Rate the severity of pain on a scale of:
1 (least pain) to 10 (severe pain) _____
Type of pain: Sharp Dull Throbbing Numbness Stiffness Swelling
(please circle) Burning Shooting Tingling Cramps Aching 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
(please circle)
Activities or movements that are painful to perform:
(please circle) Sitting Standing Walking Bending Lying Down Other



In Line Chiropractic
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Health History

What treatment have you already received for your condition?

(please circle) Medication Surgery Physical Therapy Chiropractic Services
Massage Acupuncture Other_____ None

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 _____

Please circle any of the following conditions that you have had:

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

Services that you are interested in: (please circle)

Chiropractic Care Physiotherapy Rehabilitative Services Wellness Care
Nutritional Services Craniosacral Therapy Massage Therapy Other _____

Exercise	**Work Activity**	**Habits** (please circle)	
Light	Sitting	Smoking	Packs/Day _____
Moderate	Standing	Alcohol	Drinks/Week _____
Heavy	Light Labor	Coffee/Caffeine Drinks	Cups/Day _____
Daily	Heavy Labor	High Stress Level	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

_____
_____
_____