# REGISTRATION

Date: _____ Phone: _____

Patient: _____
First Name Last Name Middle Initial

Street Address: _____

City/State/Zip Code: _____

Sex: □ M □ F Age: ____ Birthdate: _____ □Single □Married □Widowed □Separated □Divorced

Social Security #: _____ Email: _____

*Person to contact in an emergency* Name: _____ Phone #: _____

**Primary Care Physician:**

Name: _____ Phone #: _____

## Present Complaints (Please circle the appropriate ones)

| | | |
|---|---|---|
| Headache | Feet/Hands Cold | Unbalanced |
| Mental dullness | Depression | Fainting |
| Loss of memory | Rib pain | Blurred vision |
| Dizzy | Nervousness | Irritability |
| Ears ringing/buzzing | Eye strain/pain | Double vision |
| Upper back pain | Shortness of breath | Loss of smell |
| Lower back pain | Fear | Chest pain |
| Midback pain | Confusion | Neck pain |
| Pins and needles in hands right/left | Pins and needles in arms right/left | Pins and needles in legs right/left |

**Medical Implants: _____** **Medical alerts: _____**

**Surgical Implants: _____** **Pregnancy: yes ____ no ____**

**PAIN SCALE**: Rate the severity of your pain by checking a box on the following scale.

| **No Pain** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **Excruciating Pain** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |

**PATIENT INSURANCE INFORMATION:**

Patient Agreement:

**ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to **Corrective Chiropractic** all medical 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Please check any and all insurance coverage you or your spouse has applicable in this case.

| | | | |
|---|---|---|---|
| □ | Blue Cross & Blue Shield | □ | Auto Accident |
| □ | Major Medical | □ | Union Plan |
| □ | Worker's Compensation | □ | Other _____ |

Insurance Identification Number: _____

Insured's Name: _____
Last Name First Name Initial

**Medications**: *(please list all medications and supplements that you currently take)*

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

**Allergies**: *(please list all medications that cause allergic reaction)*

_____ _____
_____ _____
_____ _____

**Smoking:** ___ Yes ___ No If yes, _____ Packs per Day for _____ years

**Alcohol** ___ Yes ___ No If yes, Number of drinks per week _____

**Surgical History:** Please list ALL previous surgery and the date on which it was performed:

| Surgery | Date |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Personal Medical History & Review of Systems**: Please indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS -** no prior history of any significant medical problems

**Lungs / Pulmonary – breathing disorders**

| | | |
|---|---|---|
| □ asthma | □ pulmonary embolism | □ respiratory arrest |
| □ COPD | □ pneumonia | □ sleep apnea |
| □ emphysema | □ tuberculosis | □ other: _____ |

**Cardiac / Heart and peripheral vascular disease**

| | | |
|---|---|---|
| □ chest pain / angina | □ high blood pressure | □ irregular heartbeat, arrhythmia |
| □ heart attack, myocardial infarction | □ heart murmur, valve disorder | □ peripheral vascular disease |
| □ congestive heart failure | □ mitral valve prolapse | □ deep vein thrombosis |
| □ other: _____ | □ bleeding problems | |

**Neurologic Disorders**

□ stroke or TIA □ Parkinson's □ cerebral palsy
□ peripheral neuropathy □ MS □ polio
□ other: _____

**Bone & Joint Disorders**

□ osteoarthritis □ gout □ osteomyelitis
□ rheumatoid arthritis □ lupus □ ankylosing spondylitis
□ other: _____

**Gastrointestinal Disorders**

□ peptic ulcer or stomach ulcer □ diverticulitis □ hepatitis - Type _____
□ acid reflux, GERD □ irritable bowel □ liver disease
□ GI bleed □ inflammatory bowel disease
□ other: _____

**Genitourinary Disorders**

□ urinary tract infection □ kidney problems □ dialysis, kidney failure
□ bladder problems □ kidney stones □ other: _____

**Metabolic & Other Disorders**

□ Diabetes x _____ years □ skin disorder _____ □ depression
□ thyroid problems □ psoriasis □ anxiety
□ sickle cell disease □ any skin ulcer □ alcohol or drug dependency
□ high cholesterol or lipids □ tooth abscess, gingivitis □ other: _____

Cancer : any type -- please specify

_____

Other medical problems NOT included above (explain)

_____

_____

_____

**Family History**: Please indicate with an "X" any significant family medical history or problems.

□ asthma
□ tuberculosis
□ sleep apnea
□ COPD or Emphysema
□ other: _____

□ heart attack, myocardial infarction
□ congestive heart failure
□ irregular heartbeat, arrhythmia
□ bleeding problems
□ other: _____

□ Peripheral neuropathy
□ MS or Parkinson's
□ other: _____

□ osteoarthritis
□ Lupus
□ gout
□ rheumatoid arthritis
□ Other: _____

□ acid reflux, GERD
□ inflammatory bowel disease
□ hepatitis - Type _____
□ liver disease □ other GI:_____
□ kidney problems □ dialysis, kidney failure
□ diabetes □ psoriasis □ high cholesterol or lipids
□ thyroid problems □ sickle cell disease □ any skin ulcer
□ Malignant hyperthermia
□ Blood pressure
Cancer: any type -- please specify
_____

Other medical problems NOT included above (explain)
_____

_____

_____

**This office conforms to the current HIPPA guidelines. You may request a copy of your HIPPA policy at the front desk. Please initial to indicate you have been made aware of this availability: _____.**

**The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.**

_____
**Printed Name**

_____ _____
**Patient Signature /Guardian** **Date**