

# CHIROPRACTIC REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date \_\_\_\_\_

Patient \_\_\_\_\_

Patient Social Security # \_\_\_\_\_

Address \_\_\_\_\_

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

Email \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birth Date \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

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

Birthdate \_\_\_\_\_ Occupation \_\_\_\_\_

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

## 2 PAYMENT INFORMATION

Auto Insurance Claim  Commercial Insurance

No Insurance (Self Pay)  Medicare

Worker's Compensation

If this is a Commercial Insurance Claim, please fill out the following "Assignment and Release" and provide your health insurance card to the receptionist so she can make a copy of the card. We will file the insurance claim for you.

**ASSIGNMENT AND RELEASE**

I, the undersigned, certify that I (or my dependant) have insurance coverage with \_\_\_\_\_ and assign directly to Rocky Mountain Chiropractic and Sports Injury Centers 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

## 3 PHONE NUMBERS

Home \_\_\_\_\_ Work \_\_\_\_\_ Ext. \_\_\_\_\_

Cell \_\_\_\_\_ Best number to reach you \_\_\_\_\_

May we remind you of your next appointment via text msg?

Yes No (Circle One) If yes, what carrier? \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

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

Phone \_\_\_\_\_ Alt Ph \_\_\_\_\_

## 4 ACCIDENT INFORMATION

Is condition due to an accident?  Y  N Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?

Auto Ins  Employer  Work Comp.  Other

**Information for Auto Claims Only:**

Name of Auto Insurance: \_\_\_\_\_

Claim # \_\_\_\_\_ Ph # \_\_\_\_\_

Adjuster's Name: \_\_\_\_\_

## 5 PATIENT CONDITION

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

When did you symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark and X on the picture for pain and mark // for numbness and/or tingling.

Please Rate the Severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

Pain Rating for Past 24 hrs: \_\_\_\_\_ Pain Rating for the Past Week: \_\_\_\_\_

Type of Pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting

Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain?  Constant  Frequently (50-75% of the day)

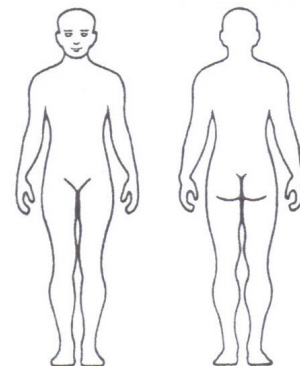
Occasionally (25-50% of the day)  Intermittently (under 25% of the day)

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform:  Sitting  Standing  Walking  Bending  Lying Down

In general, would you say that your overall health is:  Excellent  Very Good  Good  Fair  Poor

Patient Signature X \_\_\_\_\_ Date \_\_\_\_\_



# Health History

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy  
 Chiropractic Services  None  other \_\_\_\_\_

Name and address of others doctor(s) who have treated 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 place a mark to indicate if you have had any of the following:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Migraine Headaches   | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Miscarriage          | <input type="checkbox"/> Scarlet Fever   |
| <input type="checkbox"/> Allergy Shots       | <input type="checkbox"/> Fractures        | <input type="checkbox"/> Mononucleosis        | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Goiter           | <input type="checkbox"/> Mumps                | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Gout             | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Tonsillitis     |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Bleeding Disorders  | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Tumors/Growths  |
| <input type="checkbox"/> Breast Lump         | <input type="checkbox"/> Hernia           | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Typhoid Fever   |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Herniated Disk   | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Ulcers          |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problem     | Whooping Cough                           |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Prosthesis           | O Other _____                            |
| <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Liver Disease    | <input type="checkbox"/> Psychiatric Care     | _____                                    |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Measles          | <input type="checkbox"/> Rheumatoid Arthritis |  |

EXERCISE	Work Activity	Smoking	Packs/Day _____	Habits
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Alcohol	<i>Drinks/Week</i> _____	
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Coffee/Caffiene	<i>Drinks/Week</i> _____	
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High Stress Level	<i>Reason</i> _____	
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor			

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
_____	_____	_____
_____	_____	_____
_____	_____	_____

People choose chiropractic care for a number of reasons. How long you decide to benefits from chiropractic care is always up to you. Please check the type of care you desire so that we can meet your needs whenever possible.  
 Relief Care  Corrective Care  Maintenance Care  Check here if you'd like the Doctor to decide the best type for you

By my signature below , I authorize Rocky Mountain Chiropractic and Sports Injuries Centers to release any information deemed appropriate to any doctor, insurance company or attorney in the course of my treatment or in order to process any claim for reimbursement of charges. I hereby assign all the right, title and interest relative to insurance benefits to Rocky Mountain Chiropractic and Sports Injuries Centers. I clearly understand and agree that I am personally responsible for payment of all services rendered to me. Further, in the event that my account is turned over for collection, I understand that I will be responsible for any charges, attorney fees, collection costs and court cost incurred in collecting the balance.

By my signature below, I acknowledge that there are inherent risks involved with spinal manipulation. In 1995, Rand reported the risk of serious complication approximate 1 in 1 million to 1 in 1.5 million. I authorize the doctor to diagnose and treat my condition as deemed appropriate , including the use of spinal manipulation. I understand the above information and guarantee that this form was completed correctly to the best of my knowledge.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**IF MINORS, PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_