Paradise Chiropractic

PATIENT REGISTRATION AND HISTORY

PATIENT INFORMATION

DATE _____

NAME _____
ADDRESS _____
_____
CITY STATE ZIP

HOME PH._____MOBILE_____
WORK_____E-MAIL_____

SEX: ☐M ☐F AGE ____ BIRTHDATE _____/_____/_____
☐SINGLE ☐MARRIED ☐WIDOWED ☐SEPARATED ☐DIVORCED

OCCUPATION _____
EMPLOYER _____

HOW DID YOU HEAR ABOUT US? _____

PRIMARY CARE PHYSICIAN:
NAME _____
ADDRESS _____
PHONE _____ FAX _____
MAY WE CONTACT THEM TO UPDATE YOUR CONDITION? Y N

IN CASE OF EMERGENCY, CONTACT
NAME _____ RELATIONSHIP _____
HM ☎ _____ CL ☎ _____

INSURANCE

PRIMARY HOLDER'S INFORMATION:
NAME _____
BIRTHDATE _____/_____/_____
OCCUPATION _____
EMPLOYER _____
RELATIONSHIP TO PATIENT _____
IS PATIENT COVERED BY ADDITIONAL INSURANCE? ☐YES ☐NO
IF YES, WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to 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 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

ACCIDENT INFORMATION

IS THIS CONDITION DUE TO AN ACCIDENT? ☐YES ☐NO
IF SO, 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) _____ PHONE _____

PATIENT CONDITION

REASON FOR YOUR VISIT _____
_____
WHEN DID YOUR SYMPTOMS APPEAR? _____
_____
IS THIS CONDITION GETTING PROGRESSIVELY WORSE? ☐YES ☐NO
WHAT PERCENTAGE OF AWAKE TIME DO YOU HAVE THIS PAIN? _____ %
IS THE PAIN ☐CONSTANT ☐COMES AND GOES
DOES THE PAIN INTERFERE WITH YOUR:
☐WORK ☐SLEEP
☐DAILY ROUTINE ☐RECREATION
ACTIVITIES OR MOVEMENTS THAT ARE PAINFUL TO PERFORM:
☐SITTING ☐STANDING
☐BENDING ☐LYING DOWN
☐WALKING

PLEASE LIST ANY INJURIES OR SURGERIES THAT YOU HAVE HAD IN THE PAST:

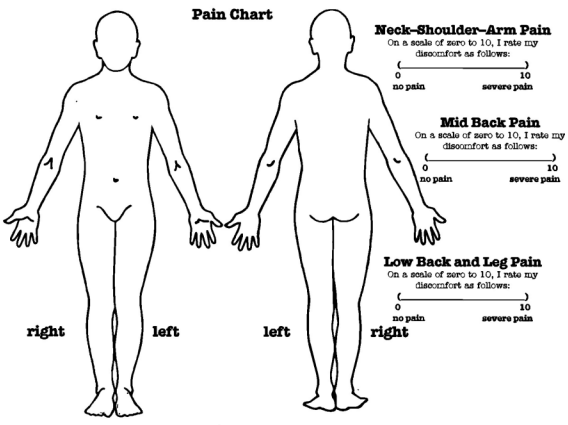
	DESCRIPTION	DATE
FALLS		
HEAD INJURIES		
FRACTURES		
DISLOCATIONS		
SURGERIES		

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols.
Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////

Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.



Health History — Paradise Chiropractic

Have you ever had cancer? ☐No ☐Yes, specify _____
Does your pain ever wake you from a sound sleep? ☐No ☐Yes, last occurrence _____
Are you losing weight now without trying? ☐No ☐Yes, reason _____
Do you cough up blood or notice any in your stool or urine? ☐No ☐Yes, last occurrence _____
Have you had any loss of bladder or bowel control? ☐No ☐Yes, last occurrence _____
Have you lost conciousness or had double vision recently? ☐No ☐Yes, last occurrence _____
Are you taking any medications or over-the-counter drugs? ☐No ☐Yes, specify _____
Do you have any known allergies? ☐No ☐Yes, specify _____
Are you taking any vitamins, herbs, minerals, or supplements? ☐No ☐Yes, specify _____

What treatment have you already received for your condition?

☐Medications ☐Chiropractic Services ☐Physical Therapy
☐Surgery ☐None ☐Other _____

Name and address of other doctor(s) who have treated you for your condition

1. _____ ☐D.C. ☐M.D. ☐Other _____
Doctor's Name

_____
Address City State Zip Code Phone

2. _____ ☐D.C. ☐M.D. ☐Other _____
Doctor's Name

_____
Address City State Zip Code Phone

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 indicate with a ☑ if you have had or currently have any of the following conditions:

☐AIDS/HIV	☐Cataracts	☐Hepatitis	☐Osteoporosis	☐Stroke
☐Alcoholism	☐Chemical dependency	☐Hernia	☐Pacemaker	☐Thyroid problems
☐Allergy shots	☐Depression	☐Herniated disc	☐Parkinson's disease	☐Tonsillitis
☐Anemia	☐Diabetes	☐Herpes	☐Pinched nerve	☐Tuberculosis
☐Appendicitis	☐Emphysema	☐High cholesterol	☐Pneumonia	☐Tumors, growths
☐Arthritis	☐Epilepsy	☐ Joint Replacement	☐Polio	☐Typhoid fever
☐Asthma	☐Fractures	☐Liver disease	☐Prostate problems	☐Ulcers
☐Bleeding disorders	☐Glaucoma	☐Measles	☐Prosthesis	☐Whooping Cough
☐Breast Lump	☐Goiter	☐Migraine headaches	☐Psychiatric care	☐Other _____
☐Bronchitis	☐Gonorrhea	☐Mononucleosis	☐Rhematoid arthritis	_____
☐Bulemia	☐Gout	☐Multiple sclerosis	☐Rheumatic fever	_____
☐Cancer	☐Heart disease	☐Mumps	☐Scarlet fever	_____

Social History

Exercise:	☐None	☐Moderate (1-3x/wk)	☐Daily (4-6x/wk)	☐Heavy (7x/wk)
Work Activity:	☐Sitting	☐Standing	☐Light Labor	☐Heavy Labor
Smoking:	☐Yes	☐No	Packs/Day	_____
Alcohol:	☐Yes	☐No	Drinks/Week	_____
Coffee/Caffeine Drinks:	☐Yes	☐No	Cups/Day	_____
High Stress Level:	☐Yes	☐No	Reason	_____
Are you Pregnant?	☐Yes	☐No	Due Date	_____
Take Birth Control?	☐Yes	☐No	Kind and Type	_____

Date of Last Menses: _____

Family History

Does your mother or father have/had any of the following: *(Please indicate **M** for mother, **F** for father, or **B** for both)*

____	Arthritis/Rheumatism	____	HIV Positive	____	Osteoporosis
____	High Blood Pressure	____	Heart Attack	____	Asthma
____	Cancer	____	Stroke	____	Emphysema
____	Diabetes	____	Pacemaker	____	Kidney Disease
____	Fatalities/Deaths	____	Circulation Problems	____	Thyroid Disease
____	Genetic Predispositions	____	Seizures/Covulsions		