# PATIENT REGISTRATION

Today's Date:

## PATIENT INFORMATION

Name:

Name Preferred to Be Called:

Date of Birth:

Social Security #:

Mailing Address:

City, State, Zip:

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Home Phone #:

Cell Phone #:

Work Phone #: Ext:

Email Address:

Referred To Us By:

## PRIMARY CARE PHYSICIAN

Primary Care Physician:

Street Address:

City, State, Zip:

Facility Name:

Phone #:

Fax #:

## INSURANCE INFORMATION

Primary Insurance:

Subscriber's Name:

Subscriber's Birthday:

Policy No:

Relationship to Subscriber:
☐Self ☐Spouse ☐Dependant ☐Other

Subscriber's Employer:

Employer's Address:

City, State, Zip:

Employer's Phone #: Ext.

Secondary Insurance:

Subscriber's Name:

Subscriber's Birthday:

Policy No:

Relationship to Subscriber:
☐Self ☐Spouse ☐Dependant ☐Other

Subscriber's Employer:

Employer's Address:

City, State, Zip:

Employer's Phone #: Ext.

## IN CASE OF EMERGENCY

Please Contact:

Relationship to Patient:

Home Phone #:

Alternate Phone #:

***Assignment & Release*** *- By signing below, I authorize Chester Chiropractic Office to release medical records required by my insurance company(s) to obtain precertification or payment. I authorize my insurance company(s) to pay benefits directly to Chester Chiropractic Office and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred due to non-payment on this account. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

Patient / Guardian

Date

# PATIENT HEALTH HISTORY

IF YOU ARE PRESENTLY TROUBLED BY A PARTICULAR CONDITION OR HAVE EVER HAD A LISTED CONDITION IN THE PAST, PLEASE CHECK IT IN THE YES COLUMN. THE INFORMATION YOU PROVIDE CONCERNING PAST AND PRESENT CONDITIONS ASSIST YOUR DOCTOR IN MORE THOROUGHLY UNDERSTANDING YOUR STATE OF HEALTH. THIS QUESTIONNAIRE IS COMPLETELY CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT YOUR SPECIFIC CONSENT

| Yes | No | |
|---|---|---|
| ___ | ___ | 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) |
| ___ | ___ | Joint ☐ Swelling (719.0) / ☐ Stiffness (719.5) |
| ___ | ___ | Fainting (780.2) |
| ___ | ___ | Visual Disturbances (728.9) |
| ___ | ___ | Convulsions (780.3) |
| ___ | ___ | Dizziness (780.4) |
| ___ | ___ | Headache (784.0) |
| ___ | ___ | Muscular Incoordination (781.3) |
| ___ | ___ | Tinnitus (Ear Noises) (388.30) |
| ___ | ___ | Rapid Heart Beat (785.0) |
| ___ | ___ | Chest Pain (786.50) |
| ___ | ___ | Loss of Appetite (783.0) |
| ___ | ___ | Irritable Colon (564.1) |
| ___ | ___ | Excessive Thirst (783.5) |
| ___ | ___ | Chronic Cough (786.2) |
| ___ | ___ | Chronic Sinusitis (473.9) |
| ___ | ___ | General Fatigue (780.7) |
| ___ | ___ | Irregular Menstrual (626.4) |
| ___ | ___ | Profuse Menstrual (611.72) |
| ___ | ___ | 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 Swallowing (787.2) |
| ___ | ___ | ☐ Heartburn / ☐ Indigestion (787.1) |
| ___ | ___ | ☐ Dermatitis / ☐ Eczema / ☐ Rash (692.9) |
| ___ | ___ | Depression (311.9) |

| Yes | No | |
|---|---|---|
| ___ | ___ | Aortic Aneurysm (441.5) |
| ___ | ___ | High Blood Pressure (401.9) |
| ___ | ___ | Angina (413.9) |
| ___ | ___ | Heart Attack (411.0) |
| ___ | ___ | Stroke (436.9) |
| ___ | ___ | Asthma (439.9) |
| ___ | ___ | Cancer ☐ Past (V10) ☐ Present (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 ☐ Type I (250.01) ☐ Type II (250.00) |
| ___ | ___ | Epilepsy (349.5) |
| ___ | ___ | Ulcer (556.9) |
| ___ | ___ | ☐ Liver (573.9) / ☐ Gallbladder Problems (575.9) |
| ___ | ___ | Kidney Stones (592.0) |
| ___ | ___ | Hepatitis (573.3) |
| ___ | ___ | Bladder Infection (595.9) |
| ___ | ___ | Kidney Disorders (V11.03) |
| ___ | ___ | Colitis (558.9) |
| ___ | ___ | Abnormal Weight ☐ Gain (783.1) / ☐ Loss (783.2) |
| ___ | ___ | HIV (V08) /AIDS (042) |
| ___ | ___ | Anorexia (307.1) |
| ___ | ___ | Systemic Lupus (710.0) |
| ___ | ___ | Other ______________________ |

| Yes | No | |
|---|---|---|
| ___ | ___ | Tobacco ☐ Present (305.1) ☐ Past (V15.82) |
| ___ | ___ | Alcohol If Yes, Frequency: ____________ |
| ___ | ___ | ☐ Drug / ☐ Alcohol Dependence (V11.3/303.99) |
| ___ | ___ | ☐ Coffee / ☐ Tea / ☐ Caffeinated Soft Drinks Servings per Day: ____________ |
| ___ | ___ | Hospitalization / Surgeries: ____________ |
| ___ | ___ | Prior Accidents/Injuries: ____________ |
| ___ | ___ | Current Medications (Rx, OTC, Vitamins): ____________ |

| Yes | No | |
|---|---|---|
| ___ | ___ | Do You Have A Permanent Disability Rating? |

Area of the Body Affected: ____________

Date Rating Received: ____________

Rating Percentage: ____________

**Please List Any Known Allergies:** ____________

**Weight** ________lbs **Height** ____Ft ____In

**Immediate Family Medical History**

| | | | |
|---|---|---|---|
| ___ | Cancer (V16) | ___ | Chronic Back Problems (V17.89) |
| ___ | Heart Problems (V17.4) | ___ | Chronic Headaches (V19.8) |
| ___ | Lung Problems (V17.6) | ___ | High Blood Pressure (V17.49) |
| ___ | Diabetes (V18.0) | ___ | Rheumatoid Arthritis (V17.7) |
| ___ | Epilepsy (V17.2) | ___ | Other Condition(s): ________ |
| ___ | Lupus (V19.8) | | ____________ |

**For Women**

| Yes | No | |
|---|---|---|
| ___ | ___ | Are You On Any Form Of Birth Control? |
| ___ | ___ | Are You Nursing? |
| ___ | ___ | Are You Or Could You Be Pregnant? |

If Yes, How Far Along? ____________

If No, Last Period? ____________

______________________ Patient Signature

______________________ Date

*Donald Littlejohn, DC ~ Chester Chiropractic Office ~ 7 Academy Avenue, Chester NY 10918*
*Phone (845) 469-7575 ~ Fax (845) 469-9328 ~ Emergency (845) 987-2840*

**PATIENT HEALTH QUESTIONNAIRE**

**Patient Name:** ______________________________

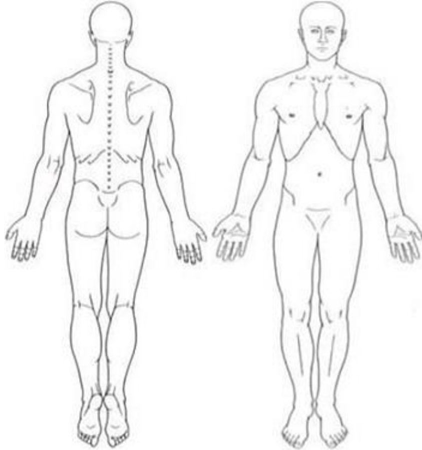
**1. What is the reason for your visit today?** ______________________________

a. Approximately when did this current episode start? ______________________________

b. What brought on this current episode? ______________________________

c. Is this episode a worsening of a prior injury? O No O Yes, it was: OWork-related OAuto Accident OOther

**2. Location:** Where does it hurt?



**3. Nature of Symptoms**

- O Numbness
- O Tingling
- O Stiffness
- O Dull
- O Aching
- O Cramps
- O Nagging
- O Sharp
- O Burning
- O Shooting
- O Throbbing
- O Stabbing
- O ______________
- O ______________

**4. Intensity of Symptoms:**

| | None | | | Mild | | | Moderate | | | Severe | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Currently: | ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| At its worst: | ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| At its best: | ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

**5. Duration:** How often do you experience symptoms?

- O Constantly (76-100% of the day)
- O Frequently (51-75% of the day)
- O Occasionally (56-50% of the day)
- O Intermittently (0-25% of the day)

**6. Aggravating or Relieving Factors:**

What makes your symptoms worse? ______________________________

What makes your symptoms better? ______________________________

**7. Prior Treatment:** What have you done to relieve the symptoms?

O Chiropractic O Acupuncture O Prescription Meds: ______________________________

O Physical Therapy O Massage O Over-the-Counter Meds: ______________________________

O Surgery O ______________ O Homeopathic Remedies: ______________________________

**8. Activities of Daily Living:** How much does this condition interfere with your life and ability to function?

| Activity | None | Mild | Moderate | Severe |
|---|---|---|---|---|
| Sitting | O | O | O | O |
| Rising out of chair | O | O | O | O |
| Standing | O | O | O | O |
| Walking | O | O | O | O |
| Lying down | O | O | O | O |
| Bending over | O | O | O | O |
| Climbing stairs | O | O | O | O |
| Lifting objects | O | O | O | O |
| Reaching overhead | O | O | O | O |
| Shopping | O | O | O | O |
| Household chores | O | O | O | O |
| Yard Work | O | O | O | O |

| Activity | None | Mild | Moderate | Severe |
|---|---|---|---|---|
| Using a computer | O | O | O | O |
| Getting in/out of car | O | O | O | O |
| Driving/Riding in a car | O | O | O | O |
| Looking over shoulder | O | O | O | O |
| Exercising | O | O | O | O |
| Caring for family | O | O | O | O |
| Showering or bathing | O | O | O | O |
| Dressing myself | O | O | O | O |
| Social life | O | O | O | O |
| Getting to sleep | O | O | O | O |
| Staying asleep | O | O | O | O |
| Concentrating | O | O | O | O |

**9. What is your current work status?**

O Working – Full Duty O Unemployed............last date worked _______/_______/_______

O Working – Modified Duty O Retired..................last date worked _______/_______/_______

**10. What is your current occupation?**

O Homemaker O Full-Time Student O Retired O ______________________________

**11. Current: Height** _____ feet _____ inches **Weight** _______ pounds **Smoking Status:** ______________

**12. Additional Comments:** ______________________________

______________________________

**Patient Signature** ______________________________ **Date** ______________

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