

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 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 <input type="checkbox"/> Upper Arm or <input type="checkbox"/> Elbow (719.42)
___	___	Hand Pain (719.44)
___	___	Wrist Pain (719.43)
___	___	Upper Back Pain (724.1)
___	___	Low Back Pain (724.2)
___	___	Pain in <input type="checkbox"/> Upper Leg or <input type="checkbox"/> Hip (719.45)
___	___	Pain in <input type="checkbox"/> Lower Leg or <input type="checkbox"/> Knee (729.5)
___	___	Pain in <input type="checkbox"/> Ankle or <input type="checkbox"/> Foot (719.47)
___	___	Jaw Pain (526.9)
___	___	Joint <input type="checkbox"/> Swelling (719.0) / <input type="checkbox"/> 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 <input type="checkbox"/> Soreness / <input type="checkbox"/> 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)
___	___	<input type="checkbox"/> Constipation / <input type="checkbox"/> Irregular Bowel Habits (564.0)
___	___	Difficulty Swallowing (787.2)
___	___	<input type="checkbox"/> Heartburn / <input type="checkbox"/> Indigestion (787.1)
___	___	<input type="checkbox"/> Dermatitis / <input type="checkbox"/> Eczema / <input type="checkbox"/> 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 <input type="checkbox"/> Past (v10) <input type="checkbox"/> 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 <input type="checkbox"/> Type I (250.01) <input type="checkbox"/> Type II (250.00)
___	___	Epilepsy (349.5)
___	___	Ulcer (556.9)
___	___	<input type="checkbox"/> Liver (573.9) / <input type="checkbox"/> Gallbladder Problems (575.9)
___	___	Kidney Stones (592.0)
___	___	Hepatitis (573.3)
___	___	Bladder Infection (595.9)
___	___	Kidney Disorders (v11.03)
___	___	Colitis (558.9)
___	___	Abnormal Weight <input type="checkbox"/> Gain (783.1) / <input type="checkbox"/> Loss (783.2)
___	___	HIV (v08) /AIDS (042)
___	___	Anorexia (307.1)
___	___	Systemic Lupus (710.0)
___	___	Other _____

Yes	No	
___	___	Tobacco <input type="checkbox"/> Present (305.1) <input type="checkbox"/> Past (v15.82)
___	___	Alcohol If Yes, Frequency: _____
___	___	<input type="checkbox"/> Drug / <input type="checkbox"/> Alcohol Dependence (v11.3/303.99)
___	___	<input type="checkbox"/> Coffee / <input type="checkbox"/> Tea / <input type="checkbox"/> Caffeinated Soft Drinks
___	___	Servings per Day: _____
___	___	Hospitalization / Surgeries: _____
___	___	Prior Accidents/Injuries: _____
___	___	Current Medications (Rx, OTC, Vitamins): _____

Please List Any Known Allergies: _____

Yes No

___ ___ Do You Have A Permanent Disability Rating?

Area of the Body Affected: _____

Date Rating Received: _____

Rating Percentage: _____

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



Last name

First name

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

1. Why are you here today? If there are many reasons, please choose only the most important or most severe one.

- | | | | |
|--|--------------------------------|-----------------------------|--------------------------------|
| <input type="radio"/> Neck | <input type="radio"/> Shoulder | <input type="radio"/> Hip | <input type="radio"/> Headache |
| <input type="radio"/> Upper/
mid back | <input type="radio"/> Elbow | <input type="radio"/> Knee | <input type="radio"/> Other |
| <input type="radio"/> Lower back | <input type="radio"/> Wrist | <input type="radio"/> Ankle | |
| | <input type="radio"/> Hand | <input type="radio"/> Foot | |

2. When did this problem first begin?

- Less than 1 month ago 1-3 months ago 4-6 months ago 7-12 months ago More than 1 year ago

Has this problem... No Yes

3. ... resulted from a work injury (i.e. workers' compensation insurance claim)? No Yes

4. ... resulted from a motor vehicle accident (i.e. no fault insurance claim)? No Yes

5. ... recently been evaluated by a medical doctor? No Yes

Since this problem began, have you noticed... No Yes

6. ... so much weakness in both your arms that you are unable to lift them? No Yes

7. ... so much weakness in both your legs that you are unable to walk without help? No Yes

8. ... difficulty controlling your bowel or bladder, or have you been unable to urinate? No Yes

9. ... pain in your chest, shortness of breath, or coughing up blood? No Yes

10. ... that one leg felt more warm, more swollen, more red, or more tender than the other? No Yes

Have you recently... No Yes

11. ... had blurred vision, double vision, dizziness, or fainting? No Yes

12. ... had any type of infection, fever, or chills? No Yes

13. ... had any type of surgery, surgical procedure, or medical procedure? No Yes

14. ... lost a lot of weight without really trying to (i.e. without being on a diet)? No Yes

15. ... had any type of accident, fall, or trauma? No Yes

Have you ever... No Yes

16. ... been diagnosed with cancer? No Yes

17. ... been diagnosed with osteoporosis (i.e. weak, soft, or brittle bones)? No Yes

18. ... been diagnosed with a weakened immune system? No Yes

19. ... used any injected drugs (i.e. non-prescription drugs)? No Yes

20. ... used steroids such as prednisone for more than 4 weeks? No Yes

Is this problem something that ... No Yes

21. ... you've had before? No Yes

22. ... generally gets worse (i.e. more severe or frequent) with movement, activity, or exercise? No Yes

23. ... generally gets better (i.e. less severe or frequent) with rest? No Yes

24. ... was recently examined with diagnostic imaging tests such as x-rays, MRI scan, or CT scan? No Yes

25. ... is also being treated by a health professional other than a chiropractor? No Yes

Service Date: / /

M M D D Y Y Y Y



