

Midtown Chiropractic Patient Registration and History

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

City _____ State _____ Zip Code _____

Sex Male Female Age _____ Birth date _____

Single Married Widowed Separated Divorced

Patient S.S.# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birth Date _____

Occupation _____

Spouse's Employer _____

How did you hear about us? _____

Your E-mail: _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____ Employer _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birth Date _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____ Employer _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Midtown Chiropractic all insurance benefits, if any, otherwise payable to me for all 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 _____

Cell Phone _____

In case of emergency, contact

Name _____ Relationship _____

Phone _____ Alt. phone _____

4 ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____

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) _____

5 PATIENT CONDITION

Reason for visit _____

When did your symptoms appear? _____

Dates of similar symptoms _____

Is this condition getting progressively worse? Yes No Unknown

Please mark an "X" on the picture above where you continue to have pain, numbness, or tingling

Rate the severity of your condition on a scale of 1(mild)-10(very severe) _____

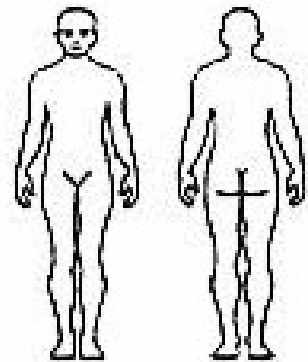
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant, or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

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



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HEALTH HISTORY

What treatments have you already received for your condition? Medications Surgery Physical Therapy
 Chiropractic Services None Other _____

Name and contact information for other 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 _____	

Place a mark on the "Yes" to indicate if you have had any of the following:

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

Exercise <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	Work Activity <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	Habits <input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Coffee/Caffeine Drinks <input type="checkbox"/> High Stress Level	Packs/Day _____ Drinks/Week _____ Cups/Day _____ Reason _____
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Are you pregnant? Yes No If Yes, Due Date _____

Injury/Surgeries you have had:	Description	Dates
Falls:	_____	_____
Head Injuries:	_____	_____
Broken Bones:	_____	_____
Dislocations:	_____	_____
Surgeries:	_____	_____

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MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

Pharmacy name: _____

Pharmacy phone: _____