

CHIROPRACTIC REGISTRATION AND HISTORY

Casper Chiropractic ~ 101 Herkimer rd. Utica NY, 13502 ~ 315-735-0903

Please do not leave any blanks - Draw a line if it does not apply

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID# _____

Patient Name _____ DOB _____ Sex M F
Last First Middle Initial

Married Widowed Single Minor Separated Divorced Partnered Number of Children _____

Address _____ Apt # _____ City _____ State _____ Zip _____ Email _____

Home Phone _____ Cell Phone _____

IN CASE OF EMERGENCY, CONTACT

Name / Relationship _____ Home Phone _____ Cell Phone _____

EMPLOYMENT

Patient Employer/School Name _____ Occupation _____

Employer/School Address _____ City _____ State _____ Zip _____ Employer Phone _____

Spouse/Partner

Name _____ DOB _____ SS# _____

Employer _____

PATIENT CONDITION

Reason for visit _____

When did your symptoms first appear? _____

Is the condition getting progressively worse? Yes No Unknown

Mark an **X** on the picture to the right, where you continue to have pain, numbness, or tingling.

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

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

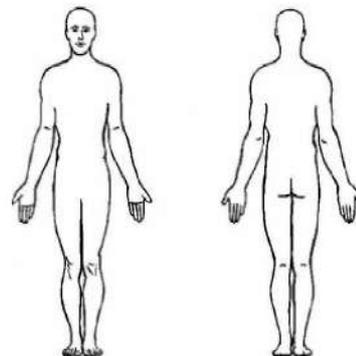
How often do you have this pain? _____

Is the pain constant or comes and goes? _____

Does it interfere with Work Sleep Daily Routine Recreation

What helps to alleviate your condition? _____

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



INSURANCE INFORMATION

Who is responsible for account? _____ Relationship to Patient _____

Insurance Co. _____ Group # _____

Is Patient covered by additional insurance? Yes No Subscriber's Name _____

Relationship to Patient _____ DOB _____ SS# _____

Insurance Co. _____ Group # _____

ASSIGNMENT & RELEASE

I certify that I, and/or my dependant(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company

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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Person Responsible _____

Date _____

Please print name of Patient, Parent, Guardian or Person Responsible _____

Relationship to Patient _____

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 Ins. Employer Workers Comp Other _____

Attorney Name (if applicable) _____

Health History

Medical Doctor's Name _____

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for 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 "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | | | |
|---------------|--|------------------|--|--------------------|--|------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraines | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tosillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Dis. | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Dis. | <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Inf. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Dis. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other: | _____ |
| Chemical Dep. | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | _____ |
| Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arth. | <input type="checkbox"/> Yes <input type="checkbox"/> No | | _____ |

EXERCISE

- None
- Daily
- Moderate
- Heavy

WORK ACTIVITY

- Sitting
- Light Labor
- Standing
- Heavy Labor

HABITS

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Packs/Day _____
 Drinks/Week _____
 Cups/Day _____
 Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had:

Description

Date

| | | |
|----------------|-------|-------|
| Falls | _____ | _____ |
| Head Injuries | _____ | _____ |
| Broken Bones | _____ | _____ |
| Auto Accidents | _____ | _____ |
| Surgeries | _____ | _____ |

Medications _____

Allergies _____

Vitamins/Herbs/Minerals _____

SIGNATURES

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Whom may we thank for referring you? _____