CHIROPRACTIC REGISTRATION AND HISTORY

Casper Chiropractic ~ 441 Trenton Road, 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

_____ _____
Emplyer/School Address City State Zip Employer Phone

Spouse/Partner

Name _____ DOB _____ SS# _____

Employer _____

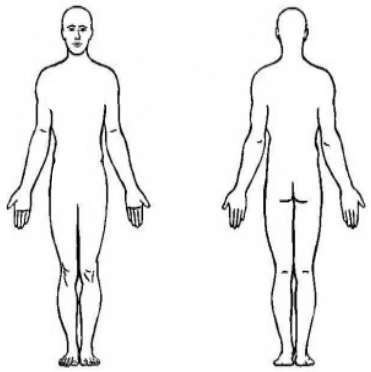
PATIENT CONDITION

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

EXERCISE

☐ None ☐ Daily
☐ Moderate ☐ Heavy

WORK ACTIVITY

☐ Sitting ☐ Light Labor
☐ Standing ☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level 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? _____