CHIROPRACTIC REGISTRATION & HISTORY

Patient Information

Date: ____________________

Patient First Name:___________________________

Patient Last Name: ___________________________

Street Address:_______________________________

City:____

State:_________________ Zip:________________

Home Phone No.:_____________________________

Cell Phone No.:______________________________

Work Phone No.:_____________________________

Email Address:_______________________________

Date of Birth:____________________ Age:_______

Marital Status:

ð Single ð Married ð Divorced ð Widowed

Social Security No.:___________________________

Referred by:__________________________________

Occupation:__________________________________

Employer/School:_____________________________

Spouse's Name:_______________________________

Spouse's Work Number:_______________________

Number of children: ________

Accident Information

Is your condition due to an accident? ð Yes ð No

If so, type of accident?

ð Auto ð Work ð Home ð Other:________

Have you made a report of your accident to:

ð Auto Insurance ð Employer ð Workers Comp

Attorney Name (if applicable)___________________

Attorney Address:_____________________________

____

Insurance Information

Do you have health insurance? ð Yes ð No

Who is responsible for this account?_____________

Relationship to patient:________________________

Insurance Company:_____________________________

Insurance ID No.:______________________________

Are you covered by additional insurance?

ð Yes ð No

Insurance Company:_____________________________

Insurance ID No.:______________________________

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Family Chiropractic of Wethersfield, LLC 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 facility may use my health care information and may disclose such information to the patient's insurance company 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 Personal Representative

____________________ ____________________
Date *Relationship to Patient*

Personal Health History

Have you had previous chiropractic care? ð Yes ð No If yes, when? ____________________________

Date of last physical examination: ____________________________

Major complaint: ____________________________

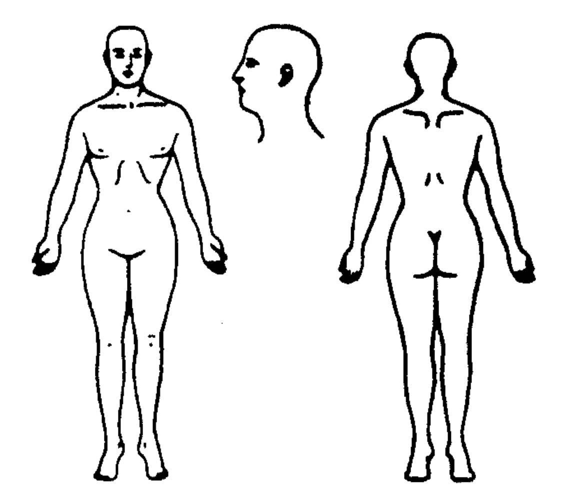
Secondary complaint: ____________________________

How long have you had this condition? __________ Is your condition getting progressively worse? ð Yes ð No

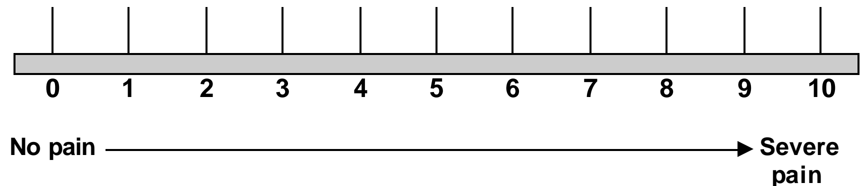
Type of pain: ð Sharp ð Dull ð Throbbing ð Numbness ð Aching ð Shooting

ð Burning ð Tingling ð Cramping ð Stiffness ð Swelling ð Other __________

Mark on the figures below any areas where you continue to have pain, numbness or tingling.



Rate your level of pain on the diagram below.



How often do you experience this level of pain? ____________________________

Is it constant or comes and goes? ð Constant ð Comes and goes

Does your pain interfere with your ð Work ð Sleep ð Daily Routine ð Recreation ð Other __________

Names of other doctors who have treated your condition: ____________________________

____

Please list any surgical operations you have had and the year performed: ____________________________

____

Current medications: ____________________________

How old is your current mattress? __________ Is your mattress: ð comfortable ð uncomfortable

Have you been in an auto accident ð In the past year ð In the past 5 years ð Over 5 years ago ð Never

Please explain: ____________________________

Have you had a personal injury ð In the past year ð In the past 5 years ð Over 5 years ago ð Never

Please explain: ____________________________

Notice of Privacy Practices

By signing below, I acknowledge that I have read and/or received a copy of the Notice of Privacy Practices. In addition, I certify that the above information is accurate and true to the best of my knowledge.

____

Signature of Patient, Parent, Guardian or Personal Representative *Date*