Positively Chiropractic Registration and History

EACH PROVIDER IN THIS OFFICE IS A SEPARATE ENTITY. THEY ARE NOT EMPLOYED BY POSITIVELY CHIROPRACTIC.

Patient Information

Date _____

SS# _____

Patient Name_____
Last Name

_____
First Name Middle Initial

Address_____

City _____

State _____ Zip _____

E-Mail _____

Sex ☐ M ☐ F Age _____

Date of Birth _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ____ yrs

Occupation _____

Patient Employer _____

Spouse's Name _____

Whom may we thank for referring you?

_____

Phone Numbers

Home Phone (_____) _____

Work Phone (_____) _____

Cell Phone (_____) _____

In Case of Emergency

Name _____ Relationship_____

Home Phone (_____)_____

Insurance Information

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Insurance ID # _____

Assignment and Release

I certify that I, and/or my dependent, have insurance coverage with _____
Name of Insurance Company

and assign directly to 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 and their agencies for the purpose of obtaining payment of services and determining insurance benefits.*Failure to pay debts will result in sending bills to collections*

_____
Signature of Patient, Parent, or Guardian

_____
Please Print the Name of the Patient, Parent, or Guardian

_____ _____
Date Relationship to Patient

Accident Information

Is the condition due to an accident? ☐ Yes ☐ No

Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other

Date of Accident _____

Patient Condition

Reason for visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No, Is it constant or does it come and go? _____

How often do you have this pain? _____

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

Type of Pain ☐ Sharp ☐ Dull ☐ Burning ☐ Tingling ☐ Throbbing ☐Cramps

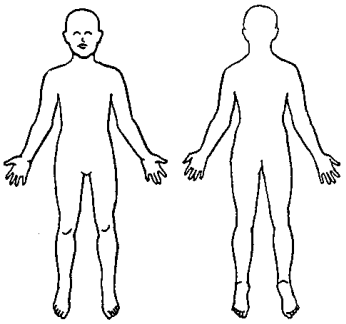
☐ Aching ☐ Numbness ☐ Swelling ☐ Shooting ☐Other _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Workouts

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking

☐ Bending ☐ Lying Down ☐ Other_____

Mark areas of Pain:



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Health History

What treatment have you already received for your condition? ☐ Chiropractic ☐ Physical Therapy ☐ Massage Therapy ☐ Surgery ☐ Acupuncture ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-rays _____ MRI, CT Scan _____

Please check ☑ conditions or symptoms you currently have or have had in the past:

☐ Aids/HIV	☐ Cancer	☐ Hernia	☐ Pace Maker	☐ Thyroid Problems
☐ Alcoholism	☐ Chemical Dependency	☐ Herniated Disk	☐ Parkinson's disease	☐ Tonsillitis
☐ Allergy Shots	☐ Chicken Pox	☐ Herpes	☐ Pinched Nerve	☐ Tuberculosis
☐ Anemia	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Tumors, Growths
☐ Anorexia	☐ Emphysema	☐ High Blood Pressure	☐ Polio	☐ Typhoid Fever
☐ Appendicitis	☐ Epilepsy	☐ Jaw Pain/TMJ	☐ Prosthesis	☐ Ulcers
☐ Arthritis	☐ Fibromyalgia	☐ Kidney Disease	☐ Prostate Problems	☐ Varicose Veins
☐ Asthma	☐ Fractures	☐ Liver Disease	☐ Psychiatric Care	☐ Vaginal Infections
☐ Bleeding Disorders	☐ Glaucoma	☐ Lymphedema	☐ Rheumatoid Arthritis	☐ Venereal Disease
☐ Blood Clots	☐ Goiter	☐ Migraine Headaches	☐ Rheumatic Fever	☐ Whiplash
☐ Breast Lump	☐ Gonorrhea	☐ Miscarriage	☐ Scarlet Fever	☐ Whooping Cough
☐ Breathing Disorders	☐ Gout	☐ Mononucleosis	☐ Sinus Problems	☐ Other _____
☐ Bursitis	☐ Head Injuries	☐ Multiple Sclerosis	☐ Stroke	
☐ Bronchitis	☐ Heart Disease	☐ Mumps	☐ Suicide Attempt	
☐ Bulimia	☐ Hepatitis	☐ Osteoporosis	☐ Tendonitis	

Medications		**Allergies**	**Vitamins/Herbs/Minerals**
Medication	Taking For		
_____	_____	_____	_____
_____	_____	_____	_____

EXERCISE	**WORK ACTIVITY**	**HABITS**	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day _____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Please list any medical conditions, surgeries, or accidents not specified above. _____ Date _____

_____ Date _____ _____ Date _____

For Massage Patients: What results would you like to achieve? _____

Prioritize the areas of your body that you wish to be massaged. _____

Please list any areas you would prefer **NOT** to be massaged. _____

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