CHIROPRACTIC
REGISTRATION and HISTORY

Patient Information

*Date: ____

*Patient: ____

*Cell Phone: ____-____-____Home Phone: ____-____-____

*Work Phone: ____-____-______

Address:____

____

Email :__________________________________

*Social Security #: _____-____-____

Date of Birth: _________ Age______

Gender: Male ___ Female ___ Race ______________

Marital Status: __ Single __ Married __ Widowed __ Separated
__ Divorced

Employer: ____

Employer address: ___________________________________

Employer's Phone: ___________________________________

**Whom may we thank for referring you?*

____

In case of emergency, contact:

Name: __________________ Relationship: ______________

Home Phone: _______________ Work: _____________

Patient Condition

Reason for Visit: _____________________________________

When did symptoms appear? ___________________________

Is condition getting progressively worse? __________________

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 ___

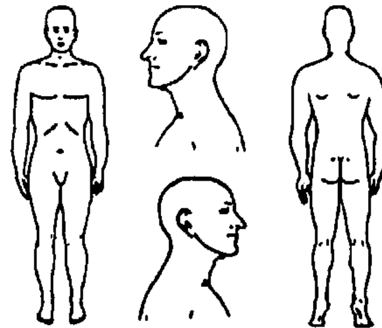
How often do you have this pain? ________________

Is it constant or does it come and go? ______________

Does it interfere with your: Work __ Sleep __
Daily Routine __ Recreation __

Activities/Movements which are painful to perform:
Sitting ___ Standing ___ Walking ___ Bending ___
Lying Down ___

Please Mark Your Areas of Pain on the Diagram Below



Insurance

Who is responsible for this account? _____________

Relationship to Patient: _______________________

Insurance Co. _______________________________

Member # ______________ Group # ____________

Is patient covered by additional insurance? ________

Subscriber's Name ___________________________

Birth Date ________ SS # ______-______-_______

Relationship to Patient: _______________________

Insurance Co. _______________________________

Member # ______________Group # _____________

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with__________ and assign directly to Dr. Tang 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 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

Accident Information

*Is this condition due to an accident? ___ yes ___ no

*Type of accident: auto ___ work ___ home ___ other ___

*Who have you reported this accident to? Auto insurance ___ Employer ___ Worker Comp. ___ Other ___

Attorney's Name (if applicable) _____________________

Exercise

__None

__Moderate

__Daily

__Heavy

Work Activity

__Sitting

__Standing

__Light Labor

__Heavy Labor

Habits

__Smoking ______Packs/Day

__Alcohol ______Drinks/Week

__Caffeine ______Cups/Day

__Stress ______Reason

List any <u>Surgeries</u>:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee

☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist

☐ Other ________________________________

Type, Dosage & Name of <u>Medications</u> you are taking:

☐ Anxiety ☐ Muscle Relaxers ☐ Pain Killers ☐ Insulin

☐ Birth control ☐ cardiovascular ☐ Allergy ☐ Seizure

☐ Other: ___________________________

List any Vitamins/Herbs and Minerals:

____

____

____

Health History

What treatment have you already received for your condition: Medications ___ Surgery ___ Physical Therapy ___ Chiropractic Services ___ 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 ______

Height __________ Weight _________

B.P .Systolic: ______ Diastolic ______

Are you pregnant? Yes____ No____

Due Date: __________________________

List any <u>Allergies</u>:

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy

☐ Dust ☐ Eggs ☐ Latex ☐ Molds ☐ Penicillin

☐ Ragweed/Pollen ☐ Rubber ☐ Seasonal Allergies

☐ Shellfish ☐ Soaps ☐ Wheat ☐ Other: __________

List <u>ALL</u> <u>Past Medical History</u> Conditions:

☐ Anemia ☐ Foot Pain ☐ Genetic Spinal Condition ☐ Hand Pain

☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Anorexia

☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain ☐ Depression

☐ Breast Lump ☐ Bronchitis ☐ Bulimia ☐ Cataracts

☐ Chemical Dependent ☐ High Blood Pressure ☐ Chicken Pox

☐ Diabetes ☐ Emphysema ☐ Epilepsy ☐ Fainting ☐ Fatigue

☐ Hernia ☐ Heart Disease ☐ Dizziness ☐ Elbow Pain ☐ Goiter

☐ Gout ☐ Glaucoma ☐ Hepatitis ☐ Headaches ☐ Hearing Problems

☐ Hepatitis ☐ Cancer ☐ Heart Problems ☐ Multiple Sclerosis

☐ Neck Pain ☐ Hip Pain ☐ AIDS/HIV ☐ Jaw Pain ☐ Joint Stiffness

☐ Venereal Disease ☐ Kidney/Liver Disease ☐ High Cholesterol

☐ Vision Problems ☐ Knee Pain ☐ Leg Pain ☐ Menstrual Problems

☐ Back Pain ☐ Mononucleosis ☐ Ulcers ☐ Stroke ☐ Hernia

☐ Neurological Problems ☐ Pacemaker ☐ Parkinson's ☐ Polio

☐ Alcoholism ☐ Allergy Shots ☐ Appendicitis ☐ Shoulder Pain

☐ Significant Weight Change ☐ Spinal Cord Injury

☐ Sprain/Strain ☐ Stroke/Heart Attack ☐ Other: _________