CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date ______

SS/HIC/Patient ID # ______

Patient Name ______
Last Name

______
First Name Middle Initial

Address ______

E-mail ______

City ______

State ______ Zip ______

Sex ☐ M ☐ F Age ______

Birthdate ______

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______

Occupation ______

Employer/School Address ______

______

Employer/School Phone (_____) ______

Spouse's Name ______

Birthdate ______

SS# ______

Spouse's Employer ______

Whom may we thank for referring you? ______

2 INSURANCE INFORMATION

Who is responsible for this account? ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______

Birthdate ______ SS# ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

ASSIGNMENT AND RELEASE

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

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. This consent will end when my current treatment plan is completed or one year from the date signed below.

______
Signature of Patient, Parent, Guardian or Personal Representative

______
Please print name of Patient, Parent, Guardian or Personal Representative

______ ______
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (______) ______ Home Phone (______) ______

Best time and place to reach you ______

IN CASE OF EMERGENCY, CONTACT

Name ______ Relationship ______

Home Phone (______) ______ Work Phone (______) ______

4 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 Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) ______

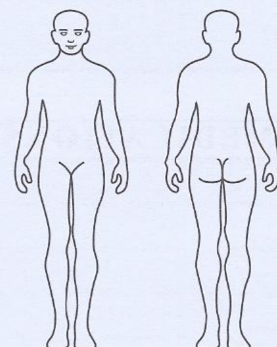
5 PATIENT CONDITION

Reason for Visit ______

When did your symptoms appear? ______

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture 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 it constant or does it come and go? ______

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

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

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6 HEALTH HISTORY

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:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other __________		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ 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		
Dislocations		
Surgeries		

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MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
__________	__________	__________
__________	__________	__________
__________	__________	__________
Pharmacy Name __________	__________	__________
Pharmacy Phone (____) __________	__________	__________

CORNERSTONE CHIROPRACTIC UPDATED PATIENT HISTORY

PATIENT NAME:____ DATE:_______________

Social History:
Marital Status: M D S W Number of Children: ______
Employed Y N Employer:_________________________________
Job Description:_____________________ Education Level: _______________

Current Health Habits:
Do you smoke? Y N How much per day? _____ Have you smoked in the past? Y N
Do you drink alcohol? Y N How much per week?___________
Diet: Do you eat healthy foods? Y N Do you eat processed foods? Y N Do you take any nutritional supplements? Y N
How much coffee/tea/caffeine do you consume daily? ____________________
Daily water intake? When thirsty 2-4 glasses 5-8 glasses 9-12 glasses Constantly, I'm always thirsty
Do you exercise? Y N How many times a week? ______ Duration ______ Sexually Active: Y N
Have you been in accidents/trauma? Y N Describe:____
____
Have you had surgery and organs removed/replaced? Y N Describe:____
____
Prescription Drugs? Y N **List and Dosage**____
____
Illegal Drugs? Y N Treated for Substance Abuse? Y N
Teeth problems? Y N Eye problems? Y N Hearing problems? Y N Allergies? Seasonal Food Drug
Do you sleep well? Y N Hours per night _____ Is it: restful restless hard to fall asleep wake often
Did/do you have occupational stress? Y N Physical stress? Y N Emotional/Mental stress? Y N
Environmental Stress? Y N Hobbies? Y N Sports? Y N Describe:_____________________________________
____

Females only – Date of last menstrual period: __________ Date of last Pap: __________ Are you pregnant? Y N
Number of pregnancies ______ Number of vaginal births ______ Cesareans ______

Family History of: please write mother, father, brother, sister or leave blank if it does not apply.

Heart Disease? _________________	Epilepsy? _____________________	Cancer? ______________________
High Blood Pressure? ____________	Arthritis? _____________________	Asthma? ______________________
Stroke? _______________________	Chronic Pain? _________________	STD's? _______________________
High Cholesterol? ______________	Tuberculosis? _________________	Depression? ___________________
Diabetes? _____________________	Thyroid Disease? _______________	Auto-Immune Diseases? __________

Cause of death if applicable for each parent or sibling? ____

Review of Systems: **Please circle C= Current N = Never or P = Past**

General: Weight loss: C N P Weight Gain: C N P
Head: Headache: C N P Dizziness: C N P Head trauma: C N P Fainting: C N P Concussion: C N P
Eyes: Changes in vision: C N P Eye Pain: C N P Double Vision: C N P
Light sensitivity: C N P Spots in vision: C N P
Mouth: Jaw pain: C N P Bleeding gums: C N P Dentures: C N P
Lungs: Difficulty breathing: C N P Wheezing: C N P Asthma: C N P Shortness of Breath: C N P
Persistent Cough: C N P Coughing blood: C N P
Vascular: Chest pain: C N P Palpitations: C N P Ankle swelling: C N P Cold feet/hands: C N P
Leg cramps: C N P Calf pain: C N P Varicose veins: C N P Low Blood Pressure: C N P
High blood pressure: C N P
Skin: Rash: C N P Easy bruising: C N P Itching/Peeling: C N P Changes in moles: C N P

CORNERSTONE CHIROPRACTIC UPDATED PATIENT HISTORY

Review of Systems Continued: **Please circle C= Current N = Never or P = Past**

GI System: Heartburn: C N P Indigestion: C N P Ulcers: C N P Vomiting/Nausea: C N P
Abdominal Pain: C N P Persistent Diarrhea: C N P Constipation: C N P Blood in stool: C N P
Hemorrhoids: C N P

G-U System: Difficulty urinating: C N P Pain urinating: C N P Blood in urine: C N P Incontinence: C N P
Increase urination: C N P

Nose: Nosebleeds: C N P Sinus problems: C N P

Neurologic: Seizures/Epilepsy: C N P Stroke/TIA: C N P Tingling: C N P Numbness: C N P
Weakness: C N P Difficulty walking: C N P Poor coordination: C N P

Muscle/bone: Joint pain: C N P Stiffness: C N P Muscle ache: C N P Bone pain: C N P

Conditions: Anemia: C N P Anxiety: C N P Arthritis: C N P Asthma: C N P
Auto-Immune Disease: C N P Cancer: C N P Cataracts: C N P Depression: C N P
Diabetes: C N P Epilepsy: C N P Gall bladder Disease: C N P Glaucoma: C N P
Gout: C N P Heart Disease: C N P High Cholesterol: C N P Liver Disease: C N P
Multiple Sclerosis: C N P Osteopenia: C N P Osteoporosis: C N P Parkinson's disease: C N P
Pneumonia: C N P Thyroid Condition: C N P Tuberculosis: C N P Urinary Infection: C N P

History of Present Illness (HPI):

Current Chief Complaint/Location: ____
____
____
____

Onset - When did your symptoms first appear?____

How did the pain start? ____

Does the pain radiate? Y N If so where? ____

Current Symptoms/Type of discomfort: Sharp Dull Aching Throbbing Burning Stinging Numbness

Other:____

Severity: 1 2 3 4 5 6 7 8 9 10 (10 is the worst)

Is the pain/discomfort: Constant (100% of time) Frequent (75% of time) Intermittent (50% of time) Occasional(25% of time)

Duration: Days Weeks Months Years

What makes it better/worse:____

Any other symptoms:____

Daily activities: Perform Perform with difficulty Unable to perform

Eye color:___________ **Eye Wear**: glasses thick glasses contacts bifocals reading none **Hair Color**:___________
Weight:__________ **Height**:_______________ **Vitals:**_____________ **Pulse:**_________________

Dr. Notes:

Any prior treatment for this condition:____

Is the onset: **Exacerbation –** flare up/activities of daily living **Aggravation –** flare up due to specific incident

Insidious – no actual traumatic event /repetitive micro trauma

Trauma/Injury Describe-____