CHIROPRACTIC REGISTRATION & HISTORY

Patient Information

Date________________________________
Patient________________________________
Address________________________________
____
Sex: M / F Age ____ Birthdate_________
__Single __Married __Widowed __Divorced/Separated
SSN________________________________
Occupation________________________________
Employer________________________________
Employer Address______________________
Employer Phone________________________
Spouse's Name________________________
Birthdate _____________ SSN ____________
Occupation________________________________
Spouse's Employer____________________
Whom may we thank for referring you?
____

Family Information

Child 1:________________________________
Age_____ DOB_______SSN____________
Child 2:________________________________
Age______DOB_______SSN____________
Child 3:________________________________
Age______DOB_______SSN____________

AGREEMENT & UNDERSTANDING

I, the undersigned, understand that I am responsible for the payment of all bills related to my (or my dependent's) treatment at Greenwood Chiropractic Clinic. I understand that my insurance benefits from _______________ will be applied to my deductible or paid to me directly.

____
Patient/Responsible Party Signature Date

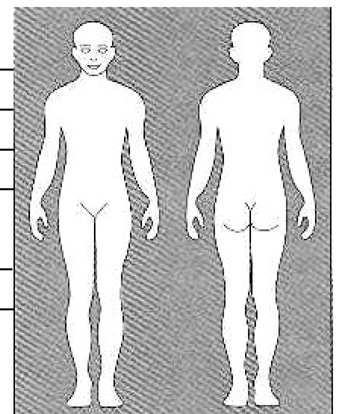
Contact Information:

Home Phone ________________ Cell Phone ________________Work Phone ______________
Best time & place to reach you__________________________
Email ____

IN CASE OF AN EMERGENCY, CONTACT: ____________________rel'p______________
Home Phone __________________ Work/Cell Phone ______________________

Patient Condition

Reason for visit ____
When did your symptoms appear? ________________________________
Is this condition getting worse? ________________________________
Rate the severity of your pain from 0 (none) to 10 (severe) _______________
Does it interfere with: __work __sleep __daily routine ___recreation
What makes it better? ____
What makes it worse? ____
Do you brush your teeth because you _____have to _____want to?



Indicate areas of pain with an X

Health History

What treatment have you **already** received for **your condition**?

__Chiropractic Treatment __Surgery __Physical Therapy __Medications __None __Other

Date of Last: Physical Exam __________Spinal Exam__________ Blood Test__________
Spinal XRay __________MRI/CT/Bone Scan __________Urine Test__________

Please circle any of the following conditions you have/had:

Allergy Shots	Diabetes I / II	Miscarriage	Stroke
Arthritis	Epilepsy	Multiple Sclerosis	Thyroid Problems
Asthma	Headaches	Osteoporosis	Other:
Bleeding Disorders	Herniated Disc	Pacemaker	________________
Cancer	Migraines	Prostate Problems	________________

EXERCISE	WORK ACTIVITIES	HABITS	
__ None	__Sitting	__Smoking	Packs/day __________
__Moderate	__Standing	__Alcohol	Drinks/week ________
__Daily	__Light Labor	__Coffee/Tea/Soda	Cups/day ___________
__Heavy	__Heavy Labor	__High Stress Level	Reason _____________

How much water do you drink each day? ____
Are you pregnant? __________________ Due Date ______________________________________
Date of Last Menstrual Cycle ________________ Date of Last Prostate Exam ____________________

Injuries/Surgeries	Descriptions	Dates
Falls	____	________________
Head Injuries	____	________________
Broken Bones	____	________________
Dislocations	____	________________
Surgeries	____	________________

Medications: ____
Allergies: ____
Supplements: ____

PLEASE LIST THE GOALS & EXPECTATIONS YOU HAVE FOR YOUR CHIROPRACTIC CARE:____
____
____

CONSENT TO TREATMENT

I acknowledge that the results of the examination I received at Greenwood Chiropractic Clinic, Inc have been explained to me. I understand these results, have been informed of possible risk factors, and have had my questions satisfactorily answered. I understand the cost of the recommended care and consent to the proposed treatment.

Signature: ___________________________________ Date: _________________________