

Chiropractic Registration and History

First Name _____ MI _____ Last name _____
Address _____ City _____ State _____ Zip _____
Phone (h) _____ (w) _____ (c) _____
Date of Birth _____ Marital Status _____
Emergency Contact _____ Phone _____ Relationship _____
Email _____
Occupation _____ Employer _____
Employer Address _____ Phone _____
Spouse _____ Spouse's Date of Birth _____
Spouse's employer _____ Phone _____
Whom may we thank for referring you? _____

Insurance Information

Insurance company _____ Subscriber _____
Subscriber DOB _____ Relationship to patient _____
ID _____ Group Number _____
Secondary Insurance company _____ ID _____

Assignment of Benefits: I certify that I am covered under the above insurance policy and assign benefits directly to Jerome Family Chiropractic, LLC. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize the use of my signature on all insurance submissions. I give Jerome Family Chiropractic, LLC permission to exchange information with the above named insurance company and my other health care providers for purposes of billing and coordination of care.

Signature _____ Date _____
Print name _____ Relationship to Patient _____

Is this condition related to an accident? Y N Type (auto, work, other) _____

Current Condition

Reason for visit _____ Is condition getting worse? Y N Unknown
When did your symptoms appear? _____ Severity of pain (1 to 10) _____
Type of pain: sharp dull aching burning numbness shooting stiffness swelling other _____
How often do you have this pain? _____ Is it constant? Y N
Does it interfere with: work sleep daily routine recreation other _____
Which activities are painful to perform? sitting standing walking bending lying down
Have you seen another doctor for this condition? Y N Name _____

Date of last x-ray/MRI _____ facility _____ purpose _____

Name of Primary Care Physician _____ Date of last physical _____

Health History

Please check the appropriate box if you have or have had any of the following.

C = currently have P = Past condition N = Never had

C	P	N	General	C	P	N	Gastro-Intestinal	C	P	N	Frequent urination
			Allergies				Constipation				Kidney stones/ disease
			Dizziness				Diarrhea				Prostate problems
			Fainting				Jaundice				Respiratory
			Fatigue				Liver Disease				Chest pain
			Headache				Nausea				Chronic cough
			Headache (migraine)				Vomiting				Difficulty Breathing

			Insomnia			Eyes, Ears, Nose & Throat	Check the following conditions that you HAVE HAD		
			Nervousness/Depression			Asthma			
			Numbness			Enlarged Glands	AIDS		Multiple Sclerosis
			Tremors			Sinus Infections	Alcoholism		Osteoporosis
			Muscle and Joint			For Women Only	Anemia		Parkinsons
			Arthritis			Breast lump	Appendicitis		Physical Abuse
			Bursitis			Cramps	Asthma		Pneumonia
			Foot Pain			Excessive menstrual flow	Bleeding disorder		Polio
			Hernia			Hot flashes	Cancer		Psychiatric care
			Low back pain			Irregular cycle	Diabetes		Rheumatoid(RA)
			Pain between shoulders			Menopausal symptoms	Eating disorder		STD
			Pain or Numbness in:			Miscarriage	Eczema		Stroke
			Neck/Upper back			Cardio-vascular	Emphysema		Substance abuse
			Shoulders			High blood pressure	Epilepsy		Suicide attempt
			Arms			Low blood pressure	Fracture		Thyroid Disease
			Elbows			High cholesterol	Goiter		Ulcers
			Hands			Pain over heart	Gout		
			Lower Back			Poor circulation	Heart Disease		
			Hips			Rapid heart rate	Hepatitis		
			Legs			Swelling in ankles/feet	Hernia		
			Knees			Genito-urinary	Herniated Disc		
			Feet			Blood in urine	Mononucleosis		

Are you pregnant? Y N Due date _____

Exercise level: None Little Moderate Heavy Days/week _____

Work Activity: Sitting Standing Light Labor Heavy Labor

Habits

Smoking Y N Packs/Day _____

Alcohol Y N Drinks/Week _____

Caffeine Y N Cups/Day _____

High Stress Level Reason _____

Injuries/Surgeries

Please list incident and date it occurred

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____

List current medications and dosages:

Vitamins and Supplements:

Allergies:

Is there anything else you would like us to know about you and your health?