Reasor Chiropractic Center
...because nature knows.

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CHIROPRACTIC REGISTRATION & HISTORY

Please **complete** the following. The information you provide us will help us to better serve you. (Please print)

1. PERSONAL INFORMATION

Date_____

Name_____
Address_____
City_____St.____Zip_____
Email_____

☐M ☐F Age____ Birthdate _____

Patient SS#_____
Driver's License # _____
☐Single ☐Married ☐Divorced ☐Widow

Occupation_____
Employer_____
Employer Address_____
Employer Phone_____

Spouse's Name_____
Spouse's Employer_____

How did you hear about us?
☐ Newspaper ☐ Radio ☐ Phone Book
☐ Sign ☐ Friend or Family_____
☐ Other _____

2. PAYMENT INFORMATION

Who is responsible for this account, You and
☐ Spouse ☐ Work Comp ☐ Auto Insurance
☐ Medicare ☐ Medicaid
☐ Other Relationship to patient_____

ASSIGNMENT AND RELEASE
I, the undersigned, certify that I (or my dependent) have the coverage with _____ And assign directly to Reasor Chiropractic Center all 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.

_____
Signature Date

(Please note that on any charges incurred today over $75: a minimum payment of $75 will be expected at the end of your first visit.)

3. PHONE NUMBERS

Home Phone_____
Work Phone_____

Emergency Contact:
Name_____
Relationship to Patient_____
Home Phone_____

4. ACCIDENT INFORMATION

Is condition due to an accident? ___Y ___N
Type of accident: ___Auto ___Work ___Other

To whom have you made a report about the accident? ___Auto Insurance ___Employer
___Work Comp. ___Other_____
Attorney name (if any)_____

PATIENT CONDITION

What is your major complaint ? _____
When did your symptoms first appear? _____
Have you had these symptoms before? □Y □N When? _____
Is this condition getting progressively worse? □Y □N □Unknown
Circle the severity of your pain on a scale from 0 (no pain) to 10 (severe pain) 1 2 3 4 5 6 7 8 9 10 10+

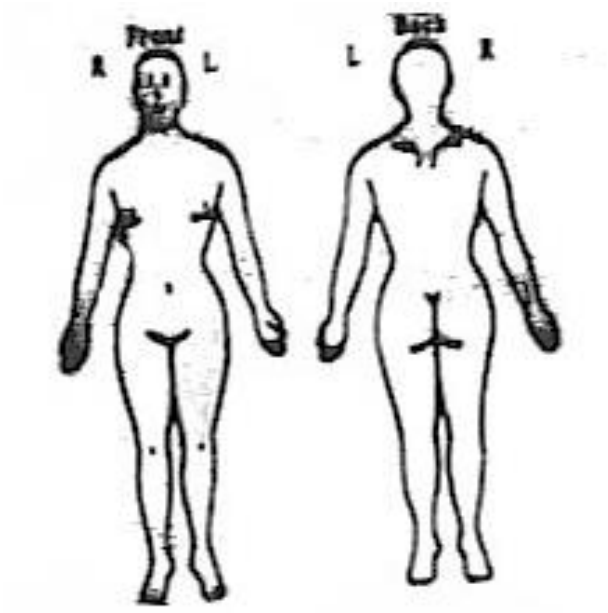
Type of pain: _____Sharp _____Dull _____Throbbing _____Numbness _____Aching
_____Shooting _____Burning _____Tingling _____Cramps _____Stiffness
_____Swelling _____Other _____

How often do you have symptoms of this condition? 0%----------50%----------100%
Is your pain □ constant **or** □ does it come and go? Explain_____

Does it interfere with your: _____Work _____Sleep _____Daily Routine _____Recreation
_____Other _____

What irritates your condition: □ Sitting □ Standing □ Walking □ Bending □ Lying Down
□ Other_____ _____
What decreases your symptoms? _____
Does your condition interfere with sleep? □Y □N I sleep on my(circle all that apply): Back Side Stomach

Mark a circle where you have numbness or tingling. Place an **X** where you have pain or discomfort.



PERSONAL HEALTH GOALS

What personal health goals would you like to achieve?

□ Symptom Relief Only	□ Health Care	□ Wellness Care
I am only interested in minimizing my immediate symptoms and reducing pain.	I am interested in reducing pain, minimizing my immediate symptoms as well as stabilization to help prevent reoccurrence in the future.	I am interested in addressing my immediate symptoms and stabilization. I am also interested in making healthy habit and lifestyle decisions to maximize my overall health and potential.

HEALTH HISTORY

What treatment have you already received for your condition? (Check all that apply) ____Chiropractic Services ____Physical Therapy ____Medication ____Surgery ____None _____Other_____

Name and location of other doctor(s) who have treated you for your condition:

_____

Have you had X-rays or an MRI in the last 12 months? □Y □N Where?_____

Have you been to see a chiropractor before? □Y □N Please list:_____

Place a check beside any of the conditions listed below which you have currently or had previously.

Current / Past	Current / Past	Current / Past
□ □ Allergies	□ □ Ear Ache	□ □ Osteoporosis
□ □ Anemia	□ □ Ear Noises	□ □ Painful Urination
□ □ Arm Pain	□ □ Emphysema	□ □ PMS
□ □ Arthritis	□ □ Endometriosis	□ □ Poor Appetite
□ □ Asthma	□ □ Failing Vision	□ □ Prostate Trouble
□ □ Backache	□ □ Fainting	□ □
□ □ Bed Wetting	□ □ Fatigue	□ □ Psoriasis
□ □ Blood Pressure	□ □ Fluid Retention	□ □ Rapid Heartbeat
___ High	□ □ Frequent Urination	□ □ Scoliosis
___ Low	□ □ Gallbladder Trouble	□ □ Sexual Dysfunction
□ □ Blood Sugar	□ □ Gas	□ □ Shingles
___ High	□ □ Hardened Arteries	□ □ Sinus Trouble
___ Low	□ □ Headache	□ □ Skin Trouble
□ □ Boils	□ □ Heart Attack	(check all that apply)
□ □ Bronchitis	□ □ Hoarseness	___ Acne
□ □ Bruise Easily	□ □ Hormone Imbalance	___ Blemish
□ □ Cancer	□ □ Hot Flashes	___ Dry
□ □ Chest Pain	□ □ Incontinence	___ Oily
□ □ Colds	□ □ Indigestion	___ Other_____
□ □ Colitis	□ □ Infections	□ □ Sprain/Strain
□ □ Constipation	□ □ Infertility	□ □ Stomach Pain
□ □ Cough	□ □ Kidney Infection	□ □ Strep Throat
□ □ Cramps	□ □ Kidney Stones	□ □ Stroke
□ □ Crohn's	□ □ Leg Pain	□ □ Swelling of Ankles
□ □ Crossed Eyes	□ □ Loss of Sleep	□ □ Thyroid Trouble
□ □ Deafness	□ □ Menopause	□ □ Tonsillitis
□ □ Dental Problems	□ □ Menstrual Problems	□ □ Tremors
□ □ Diarrhea	□ □ Nausea	□ □ Varicose Veins
□ □ Difficult Breathing	□ □ Neck Pain	□ □ Other_____
□ □ Difficult Digestion	□ □ Nosebleeds	□ □ Other_____
□ □ Dizziness	□ □ Numbness	□ □ Other_____

Last eye exam by a doctor:_____

EXERCISE
_____ None
_____ Moderate
_____ Daily
_____ Heavy
Explain_____

WORK ACTIVITY
_____ Sitting
_____ Standing
_____ Light labor
_____ Heavy labor
Explain_____

HABITS
_____ Smoking Pack/Wk _____
_____ Alcohol Drinks/Day _____
_____ Coffee/Caffeine Cups/Day _____
_____ High Stress Reason _____
Other_____

HEALTH HISTORY Page 2

Injuries/Surgeries you have had: Description Date

Falls_____ _____
Head Injuries_____ _____
Broken Bones_____ _____
Dislocations_____ _____
Surgeries_____ _____
Auto Accidents_____ _____
Other_____ _____

Hospitalizations: Reason Date

_____ _____
_____ _____
_____ _____

Are you pregnant? ☐No ☐Yes Due Date_____ Do you use contraceptives? ☐No ☐Yes
Blood type? _____ ☐Unknown Any known allergies?_____
Do you ever have impairment of bowel or urinary function? ☐Y ☐N

Please list any vitamins, minerals, herbs, over the counter medications, or prescriptions you are currently taking or have taken in the past three months.

Name	**Dosage**	**Frequency**	**Name**	**Dosage**	**Frequency**

FAMILY HISTORY

	Relative	Age if living	Age at death	Cause of death	State of health including any medical diagnoses
☐Unknown	**Father**	____	____	_____	_____
☐Unknown	**Mother**	____	____	_____	_____
☐Unknown	**Sister(s)**	____	____	_____	_____
☐Unknown	**Brother(s)**	____	____	_____	_____
☐Unknown	**Maternal Grandfather**	____	____	_____	_____
☐Unknown	**Maternal Grandmother**	____	____	_____	_____
☐Unknown	**Paternal Grandfather**	____	____	_____	_____
☐Unknown	**Paternal Grandmother**	____	____	_____	_____

Other _____