

TODAY'S DATE _____

Balkman
CHIROPRACTIC
REGISTRATION FORM

PATIENT # _____

PATIENT INFORMATIONNAME: _____
LAST FIRST MIDDLE INITIAL

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ E-MAIL: _____

CELL PHONE: _____ HOME PHONE: _____ BEST TIME TO CALL: _____

METHOD:
☐ CELL PHONE
☐ HOME PHONE

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____ MARRIED WIDOWED SINGLE

EMPLOYER: _____ OCCUPATION: _____

MEDICAL DOCTORS NAME: _____ FACILITY: _____ PHONE#: _____

EXERCISE:

- ☐ NONE
☐ MODERATE
☐ DAILY
☐ HEAVY

WORK ACTIVITY:

- ☐ SITTING
☐ STANDING
☐ LIGHT LABOR
☐ HEAVY LABOR

HABITS:

- ☐ SMOKING
☐ ALCOHOL
☐ COFFEE/SODA
☐ HIGH STRESS LEVEL

PACKS/DAY _____

DRINKS/WK _____

CUPS/DAY _____

REASON _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

HOW DID YOU HEAR ABOUT US? _____

WHAT SERVICES ARE YOU INTERESTED IN? MARK ALL THAT APPLY

- ☐ SPINAL AND BODY ALIGNMENT ☐ TREATMENT FOR PAIN ☐ STRENGTH & REHABILITATION EXERCISES
☐ INJURY PREVENTION ☐ NUTRITIONAL COUNSELING

ACCIDENT INFORMATION**IS TODAYS VISIT DUE TO:**

AUTO ACCIDENT?: (YES / NO)

WORKERS COMPENSATION?: (YES / NO)

PERSONAL INJURY?: (YES / NO)

ASSIGNMENT OF BENEFITS AND RELEASE

I hereby give lifetime authorization of payment of insurance benefits to be made directly to Dr. _____ and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I verify that all the information on this form is accurate.

SIGNATURE: _____ DATE: _____

Balkman CHIROPRACTIC

REGISTRATION FORM

HEALTH HISTORY

PLEASE CHECK ALL THAT APPLY TO YOU:

- | | | |
|----------------------------------------------|---------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> RHEUMATOID ARTHRITIS |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> DIABETES | <input type="checkbox"/> MEASLES |
| <input type="checkbox"/> ALLERGY SHOTS | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> MIGRAINE HEADACHES |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> MISCARRIAGE |
| <input type="checkbox"/> FRACTURES | <input type="checkbox"/> MONONUCLEOSIS | <input type="checkbox"/> SUICIDE ATTEMPT |
| <input type="checkbox"/> APPENDICITIS | <input type="checkbox"/> MULTIPLE SCLEROSIS | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> TONSILLITIS | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> GOUT | <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> TUMORS, GROWTHS |
| <input type="checkbox"/> BREAST LUMP | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> PARKINSON'S DISEASE |
| <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> PINCHED NERVE |
| <input type="checkbox"/> HERNIA | <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HERNIATED DISK | <input type="checkbox"/> POLIO |
| <input type="checkbox"/> HERPES | <input type="checkbox"/> PROSTATE PROBLEM | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> CHEMICAL DEPENDENCY | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> PROSTHESIS |
| <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> PSYCHIATRIC CARE | |

☐ PREGNANT DUE DATE: _____

PRIOR ILLNESS: _____

PAST HOSPITALIZATIONS: _____

SURGERIES: _____

MEDICATIONS: _____

DATE OF LAST: PHYSICAL EXAM _____ MRI, CT-SCAN, BONE SCAN _____

SYMPTOM INFORMATION

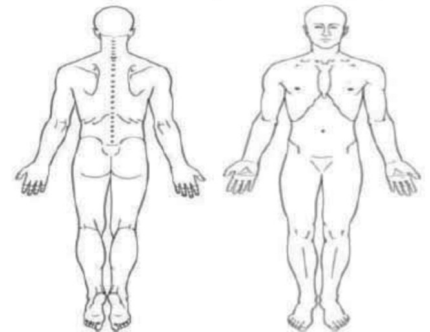
Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

--	--	--

Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms: _____

2. How did your symptoms start? _____

3. Average pain intensity:

Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain
Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

4. How often do you experience your symptoms?

(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. How is your condition changing, since care began at *this* facility?

(0) N/A — This is the initial visit (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. In general, would you say your overall health right now is...

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

Patient Signature: X Date: _____