TODAY'S DATE_____

Baldman CHIROPRACTIC

PATIENT #_____

REGISTRATION FORM

PATIENT INFORMATION

NAME: _____
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:	WORK ACTIVITY:	HABITS:	
☐ NONE	☐ SITTING	☐ SMOKING	PACKS/DAY _____
☐ MODERATE	☐ STANDING	☐ ALCOHOL	DRINKS/WK_____
☐ DAILY	☐ LIGHT LABOR	☐ COFFEE/SODA	CUPS/DAY _____
☐ HEAVY	☐ HEAVY LABOR	☐ HIGH STRESS LEVEL	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:_____

Baldwin CHIROPRACTIC

REGISTRATION FORM

HEALTH HISTORY

PLEASE CHECK ALL THAT APPLY TO YOU:

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

☐ **PREGNANT DUE DATE:**_____

PRIOR ILLNESS: _____

PAST HOSPITALIZATIONS: _____

SURGERIES: _____

MEDICATIONS: _____

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

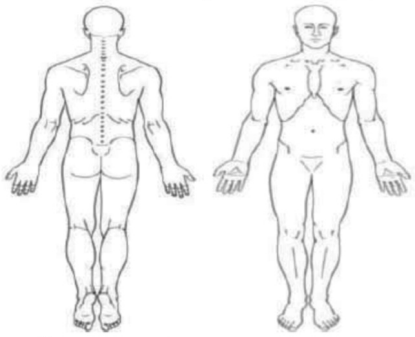
SYMPTOM INFORMATION

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:** _____