CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

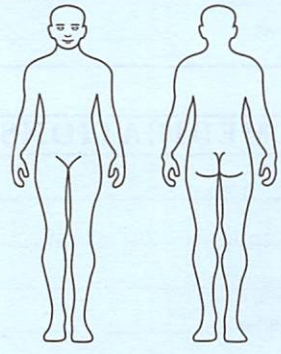
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No		
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other _____	
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

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MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name _____		
Pharmacy Phone (____) _____		

NORTHGATE CHIROPRACTIC CLINIC

PERSONAL INJURY PATIENT HISTORY

Name:_____Date: _____File:_____

Have you reported the accident to your insurance company? Yes__ No__ If no, please do so today.

Minnesota is a no-fault insurance state. Your bills will be submitted to your insurance company, whether you were the driver or a passenger. If you were a passenger and have no insurance, it will be submitted to the driver's insurer, and you will probably need to sign an affidavit stating that you have no coverage. You will get this from the insurance company when you report the accident. Please fill out and return any papers your insurance company may have given you to ensure prompt payment for your claims. Any claims not paid by your insurer will be your responsibility.

INSURANCE COMPANY INFORMATION:

Company name:_____
Address: _____
Phone #: _____ Policy #: _____
Claim #: _____ Adjuster: _____

HISTORY OF OCCURRENCE:

Date of accident: _____Time: _____am pm City/State:_____
Driver of car: _____ Owner of car: _____
Make/model and year of vehicle: _____
Where were you seated? Driver__ Front right passenger__ Front middle passenger __
Rear right passenger__ Rear middle passenger__ Rear left passenger__
How much damage was done to the vehicle? _____
Visibility at time of accident? Poor__ Fair__ Good__
Road conditions at time of accident? Snowy__ Icy__ Wet__ Clear __
My vehicle was hit__ or hit another vehicle__ in the rear__ right side__ left side__
Front__ If accident was non-collision, describe:_____
Was your vehicle braking? Yes__ No__
Was your vehicle moving at the time of the accident? Yes__ No__ Estimated speed_____mph
Estimated speed of the other vehicle:_____mph Don't know speed of other vehicle:__
Describe the accident in your own words:_____
_____
_____
Were you aware the accident was about to happen? Yes__ No__
Did you brace for the impact? Yes__ No__
Were you wearing a seat belt/shoulder harness? Yes__ No__
Airbag for your seat? Yes__ No__ If yes, did the airbag inflate at impact? Yes__ No__
Were you injured by the inflated airbag? Yes__ No__ Injuries:_____
Headrest for your seat? Yes__ No__
If yes, position of headrest compared to your head before the accident:
Top of headrest even with bottom of head__ Top of headrest even with top of head__
Top of headrest even with middle of neck__

Describe in your own words what happened to you upon impact:_____

_____

At impact: Head turned right__ head turned left__ head looking back__ head straight ahead__
Body straight in the sitting position__ body rotated right__ body rotated left__
As a result of the accident you were: rendered unconscious__ dazed, circumstances vague__
Shaken up, but could function__
Could you move all your body parts? Yes__ No__ If no, explain:_____

_____

Were you able to get out of the vehicle and walk unaided? Yes__ No__ If no, explain:_____

_____

Did you receive any medical assistance at the scene of the accident? Yes__ No__ If yes, explain:_____

SYMPTOMS FROM THE ACCIDENT:

Did you get any bleeding cuts or bruises? Yes__ No__ If yes, explain:_____

_____

Describe how you felt immediately after the accident:_____

_____

Describe how you felt later that day/night:_____

_____

Check symptoms apparent since the accident:

__Headache
__Neck pain/stiffness
__Upper back pain
__Midback pain
__Low back pain
__Arm pain
__Leg pain
__Numb toes
__Numb fingers
__Cold feet
__Cold hands
__Eyes sensitive to light
__Pain behind the eyes
__Dizziness
__Ringing/buzzing in ears
__Loss of balance
__Loss of smell
__Loss of taste
__Loss of memory
__Fatigue
__Tension
__Shortness of breath
__Irritability
__Depression
__Sleeping problems
__Diarrhea
__Constipation
__Cold sweats
__Anxiety
__Nervousness
__Other:_____
_____

FIRST DOCTOR/HOSPITAL/CLINIC FOR SYMPTOMS FROM THIS ACCIDENT:

Did you seek medical help immediately or soon after the accident? Yes__ No__
If yes, when?_____Where?_____
Were you examined? Yes__ No__ Were x-rays taken? Yes__ No__
What treatment were you given?_____
What benefits did you receive from the treatment?_____
Date of last treatment:_____

SECOND DOCTOR/HOSPITAL/CLINIC FOR SYMPTOMS FROM THIS ACCIDENT:

Date of visit:_____Place/Doctor:_____
Were you examined? Yes__ No__ Were x-rays taken? Yes__ No__
What treatment were you given?_____
What benefits did you receive from the treatment?_____
Date of last treatment:_____

OTHER DOCTOR/HOSPITAL/CLINIC FOR SYMPTOMS FROM THIS ACCIDENT:
Date of visit:_____ Place/Doctor:_____
Were you examined? Yes__ No__ Were x-rays taken? Yes__ No__
What treatment were you given?_____
What benefits did you receive from the treatment?_____
Date of last treatment:_____

If you had any medical treatment for symptoms resulting from this accident before presenting at this clinic, please fill out a Records Release form for each medical facility so we can obtain records, including x-rays, from each place. The Records Release form can be obtained from the front desk personnel.

WORK STATUS HISTORY:
Employer:_____ Address:_____
Occupation:_____ Have you missed time from work? Yes__ No__
If yes, how much time?_____

PRIOR MEDICAL HISTORY:
Did you have any physical complaints in the time period just prior to the accident? Yes__ No__
If yes, describe:_____
Prior to this accident, have you ***EVER*** had symptoms similar to what you are now experiencing?
Yes__ No__ If yes, explain:_____
_____
_____

ACTIVITIES OF DAILY LIVING:
Do you notice any change in your ability to perform home activities from before the accident?
Yes__ No__ If yes, please list specific activities below.
Those activities you are now *unable* to do:_____
_____
Those activities that cause extra *pain*:_____
_____
Those activities that are now *difficult* to do:_____
_____

ATTORNEY INFORMATION:
Do you have an attorney on this case? Yes__ No__
If yes, Name:_____ Phone #:_____
Address:_____
_____

If you do not have an attorney at this time, but choose to retain one at a later date, please inform us of the above information at that time.

Patient's signature:_____ Date:_____