CHIROPRACTIC REGISTRATION AND HISTORY-WORKERS' COMPENSATION

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____
City State Zip

Sex: ☐M ☐F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____

Email _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____ ext. _____

Spouse's Name _____

Birthdate _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Cell _____ Home _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

INSURANCE

Date of injury: _____

Have you already filed a claim? Yes ____ No ____

Have you missed any work? Yes ____ No ____

If Yes, how many days? _____

Responsible Insurer: _____

Policy Holder: _____

Policy #: _____

FINANCIAL AGREEMENT AND RELEASE

I understand that I am financially responsible for all charges rendered by Amy Spellmeyer, DC whether or not they are covered by insurance. I hereby give lifetime authorization for payment of insurance benefits directly to Amy Spellmeyer, DC accounts.

I authorize Spellmeyer Chiropractic Inc. to furnish my records to the insurance company or an attorney for the purpose of obtaining payment on my account for service provided to me.

I have received /read the HIPAA Policies of this office. I further agree that a photocopy of this agreement shall be as valid as the original.

I have read the above FINANCIAL AGREEMENT and understand it.

I hereby request and consent to the performance of chiropractic adjustments and other procedures by the doctor of Spellmeyer Chiropractic Inc. I acknowledge that more information can be provided upon my request.

_____
Responsible Party Signature

_____ _____
Relationship Date

PATIENT INFORMATION

Reason for visit _____

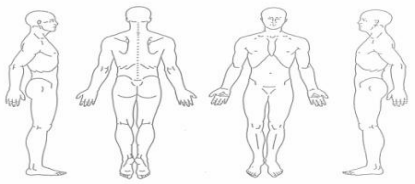
When did your symptoms appear? _____

Is this condition getting progressively worse? _____

Where do 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 Swelling
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

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

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name		
Pharmacy Phone		