



Chiropractic Registration and History

Personal and Family Health History

Name _____
 Date _____
 Address _____
 City _____ State ____ Zip _____
 Phone: (H) _____
 (Cell) _____
 E-mail _____
 Date of Birth _____ Age _____
 Sex Male Female
 If Female, are you currently pregnant? Yes No
 Family Doctor _____

Referred By _____
 Occupation _____
 Employer _____
 Marital Status S M D W
 Spouse's Name _____
 Spouse's Occupation _____
In case of Emergency, Contact
 Name _____
 Relationship _____
 Phone: (W) _____
 (Cell) _____

Number of Children, Ages, and Previous Chiropractic Care?

Name _____	Age _____	Yes ___ No ___	Reason _____
Name _____	Age _____	Yes ___ No ___	Reason _____
Name _____	Age _____	Yes ___ No ___	Reason _____
Name _____	Age _____	Yes ___ No ___	Reason _____
Name _____	Age _____	Yes ___ No ___	Reason _____

Insurance:

Who is responsible for this account? _____
 Relationship to Patient _____
 Insurance Company _____
 Group # _____ ID # _____
 Is patient covered by additional Insurance: Y N
 Subscriber's Name _____
 Birth date _____
 Relationship to Patient _____
 Insurance Company _____
 Group # _____ ID # _____

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Mike Madden 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 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

 Date

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

 Relationship to Patient

Current Health Habits

Exercise

- None
- Moderate
- Daily
- Heavy

Work Activity

- Sitting
- Standing
- Light Labor
- Heavy Labor

Injuries/Surgeries you have had

Falls _____

Head Injuries _____

Broken Bones _____

Dislocation _____

Surgeries _____

Date

Habits

- Smoking
- Alcohol
- Coffee/ Caffeine Drinks
- High Stress Level

Packs/day _____

Drinks/Week _____

Cups/Day _____

Reason _____

Current Health Condition

1. Present Complaint (be brief) Reason For Your Visit

Today _____

Pain or Problem started on _____

Pains are: (select all that apply) Intensity: 12345678910

- Sharp
- Dull/Ache
- Burning
- Constant
- Intermittent
- Occasional
- Daily
- ___ times per Week/Month

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Does this condition interfering with your

- Sleep
- Routine
- Work
- Recreation
- Other _____

Is this condition:

- getting progressively worse
- staying the same
- getting better
- Not sure

Other Doctors seen for this condition _____

Any home remedies? _____

2. Second Complaint (be brief) Reason For Your Visit

Today _____

Pain or Problem started on _____

Pains are: Intensity: 12345678910

- Sharp
- Dull/Ache
- Burning
- Constant
- Intermittent
- Occasional
- Daily
- ___ times per Week/Month

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Does this condition interfering with your

- Sleep
- Routine
- Work
- Recreation
- Other _____

Is this condition:

- getting progressively worse
- staying the same
- getting better
- Not sure

Other Doctors seen for this condition _____

Any home remedies? _____

Other symptoms:

- Headaches
- Neck Pain
- Sleeping Problems
- Back Pain
- Nervousness
- Tension
- Irritability
- Chest Pains
- Dizziness
- Face Flushed
- Neck Stiff
- Pins & Needles in Legs
- Pins & Needles in Arms
- Numbness in Fingers
- Numbness in Toes
- Shortness of Breath
- Fatigue
- Depression
- Light Bothers Eyes
- Loss of Memory
- Ears Ring
- Fever
- Fainting
- Cold Sweats
- Loss of Smell
- Loss of Taste
- Diarrhea
- Feet Cold
- Hands Cold
- Stomach Upset
- Constipation
- Loss of Balance
- Buzzing in Ear

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>