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REGISTRATION FORM

1 PATIENT INFORMATION

Date ________________

Patient Name ________________

Nickname ________________

Address ________________

City________________

State ________________ Zip ________________

SS#________________

Sex ☐ M ☐ F

☐ Married ☐Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐Partnered

Birthdate ____________ Age ________________

Employer/School ________________

Whom may we thank for referring you?________________

____

Spouse's Information

Name ________________

Birthday ________________

SS# ________________

Employer ________________

2 INSURANCE INFORMATION

Who is responsible for this account? ________________

Relationship to Patient ________________

Insurance Co. ________________

ID# ________________

Is patient covered by **additional insurance**? ☐ Yes ☐ No

Subscriber's' Name ________________

Birthdate ________________ SS# ________________

Relationship to Patient ________________

Insurance Co. ________________

ID# ________________

ASSIGNMENT AND RELEASE

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

________________ and assign directly to Berlin

Name of Insurance Company(ies)

Chiropractic Corp. 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 this information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent when my current treatment plan is complete or one year from the date signed below.

____

Signature of Patient, Guardian or Personal Representative

____

Please print name of Patient, Guardian or Personal Representative

________________ ________________

Date Relationship to Patient

3 Contact Info

Home Phone ________________

Work Phone ________________

Cell Phone ________________

E-mail________________

IN CASE OF EMERGENCY CONTACT

Name ________________

Relationship ________________

Home Phone ____________ Cell Phone ________________

Work Phone ________________

4 ACCIDENT INFORMATION

Is the condition due to an accident? ☐Yes ☐No Date _______

Type of Accident: ☐Auto ☐Work ☐Home ☐Other

To whom have you made a report of the accident?

☐Auto Insurance ☐Employer ☐Worker Comp. ☐Other

Attorney Name and contact information

____

5 MEDICAL INFORMATION

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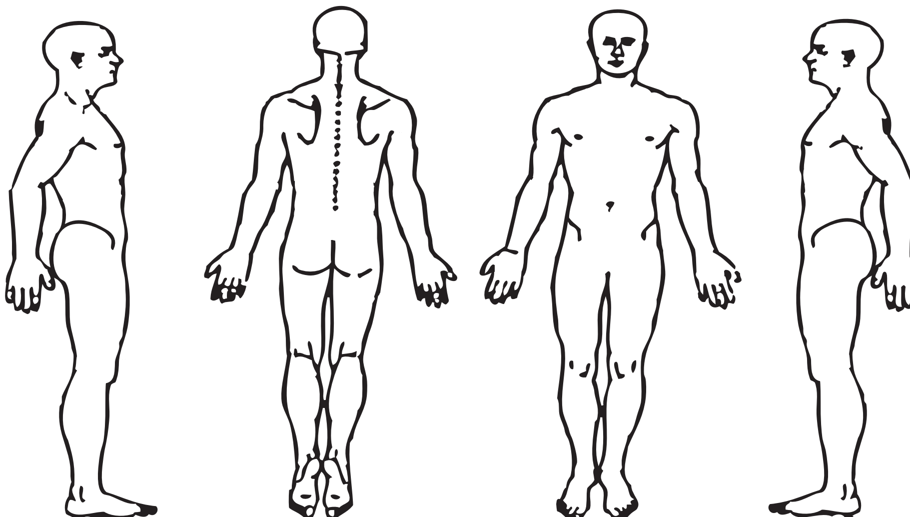
1: What is the primary reason for your visit?

____
____
____
____
____
____

2: Please indicate on the adjacent drawings where you have pain/ symptoms:



3. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the time)
- ☐ Occasionally (26-50% of the time)
- ☐ Frequently (51-75% of the time)
- ☐ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- ☐ Sharp
- ☐ Dull
- ☐ Diffuse
- ☐ Achy
- ☐ Burning
- ☐ Shooting
- ☐ Stiff
- ☐ Numb
- ☐ Tingly
- ☐ Sharp with motion
- ☐ Shooting with motion
- ☐ Stabbing with motion
- ☐ Electric like with motion
- ☐ Other:___________________

5. How are your symptoms changing with time?

☐ Getting Worse ☐ Not Changing ☐ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. Who else have you seen for your problem?

- ☐ Chiropractor
- ☐ Neurologist
- ☐ Primary Care Physician
- ☐ ER Doctor
- ☐ Orthopedist
- ☐ Other:_____________
- ☐ Massage Therapist
- ☐ Physical Therapist
- ☐ No one

10. How long have you had this problem? ___________

11. How do you think your problem began?

____

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12. Do you consider this problem to be severe?

☐ Yes ☐ Yes, at times ☐ No

13. What aggravates your problem? (ex: bending, driving, sitting, stress)

____

14. What alleviates your problem? (ex: heat, ice, massage, tylenol, adjustments)

____

15. What concerns you the most about your problem; what does it prevent you from doing?

____

16. What is your: Height____________ Weight ______________ DOB ____________

Occupation ____

17. How would you rate your overall Health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

18. What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

19. Indicate if you have any immediate family members with any of the following:

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus
☐ Heart Problems ☐ Cancer ☐ ALS

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Dizziness	☐	☐	Asthma
☐	☐	Neck Pain	☐	☐	High Blood Pressure	☐	☐	Chronic Sinusitis
☐	☐	Upper Back Pain	☐	☐	Heart Attack	☐	☐	Diabetes
☐	☐	Mid Back Pain	☐	☐	Chest Pains	☐	☐	Excessive Thirst
☐	☐	Low Back Pain	☐	☐	Stroke	☐	☐	Frequent Urination
☐	☐	Shoulder Pain	☐	☐	Angina	☐	☐	Tobacco Use
☐	☐	Arm Pain	☐	☐	Kidney Stones	☐	☐	Drug/Alcohol Dependance
☐	☐	Wrist Pain	☐	☐	Kidney Disorders	☐	☐	Allergies
☐	☐	Hand Pain	☐	☐	Bladder Infection	☐	☐	Depression
☐	☐	Upper Leg Pain	☐	☐	Painful Urination	☐	☐	SLE (Lupus)
☐	☐	Hip Pain	☐	☐	Loss of Bladder Control	☐	☐	Epilepsy
☐	☐	Knee Pain	☐	☐	Prostate Problems	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Ankle/Foot Pain	☐	☐	Abnormal Weight Change	☐	☐	HIV/AIDS
☐	☐	Jaw Pain	☐	☐	Loss of Appetite	☐	☐	Hormonal Replacement
☐	☐	Joint Swelling	☐	☐	Abdominal Pain			
☐	☐	Arthritis	☐	☐	Ulcer	For Females Only		
☐	☐	Rheumatoid Arthritis	☐	☐	Hepatitis	☐	☐	Birth Control Pills
☐	☐	General Fatigue	☐	☐	Gall Bladder Problems	☐	☐	Pregnancy
☐	☐	Muscular Incoordination	☐	☐	Cancer			
☐	☐	Visual Disturbances	☐	☐	Tumor			

21: Are you pregnant? ☐ No ☐ Yes Due Date ____________________

22.

PRESCRIPTION MEDS	OVER THE COUNTER MEDS	SUPPLEMENTS	SURGICAL PROCEDURES
Pharmacy Name:			
Pharmacy Phone:			

23. List any allergies that you have____

24. What activities do you do at work?

☐ Sit: ☐ Most of the day ☐ Some of the day ☐ A little of the day
☐ Stand: ☐ Most of the day ☐ Some of the day ☐ A little of the day
☐ Computer work: ☐ Most of the day ☐ Some of the day ☐ A little of the day
☐ On the phone: ☐ Most of the day ☐ Some of the day ☐ A little of the day
☐ Driving: ☐ Most of the day ☐ Some of the day ☐ A little of the day

25. What activities do you do outside of work? (ex: sports, exercise, yoga)

____

26. Have you had significant past trauma? ☐ No ☐ Yes

Injuries	Description	Date
Falls		
Injuries		
Broken Bones		
Dislocations		
Car accidents		

27. Have you ever been hospitalized? ☐ No ☐ Yes ☐ Previously Mentioned

If yes, why? ____

28. Have you ever seen a chiropractor before? ☐ No ☐ Yes

If yes, how long ago? ____

Was the result good, mixed or poor? ____________________________________

29. Anything else that you think I should know? __________________________________

Patient Signature ____________________________ Date:____________________