



BluegrassChiropractic | REGISTRATION & HISTORY

Patient Information

Date _____

SS # _____

Last Name _____ First Name _____

Address _____

Email _____

City _____ State _____ Zip _____

Sex: Male _____ Female _____

Birthdate _____ / _____ / _____

Home Phone _____ Cell Phone _____

Married _____ Widowed _____ Single _____ Minor _____

Separated _____ Divorced _____ Partnered _____

Employer / School _____

Occupation _____

Address _____

Phone _____

Spouse's Name _____

Spouse's Birthdate _____ / _____ / _____

SS# _____ — _____ — _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Home Phone _____ Cell Phone _____

Best Time / Place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Insurance Information

Who is responsible for this account? _____

Insurance Provider _____

ID # _____

Is patient covered by additional insurance? YES _____ NO _____

Subscribers Name _____

Birthdate _____ / _____ / _____ SS# _____ — _____ — _____

Relationship to Patient _____

Insurance Provider _____

ID # _____

ASSIGNMENT & RELEASE

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

and assign directly to 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 benefits or the benefits payable for related services. The 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

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 _____ Workers Comp _____ Other _____

Attorney Name (if applicable) _____

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 (sever pain) _____

Type of Pain: Sharp _____ Dull _____ Throbbing _____ Numbness _____ Aching _____ Shooting _____

Burning _____ Tingling _____ Cramps _____ Stiffness _____ Swelling _____ Other _____

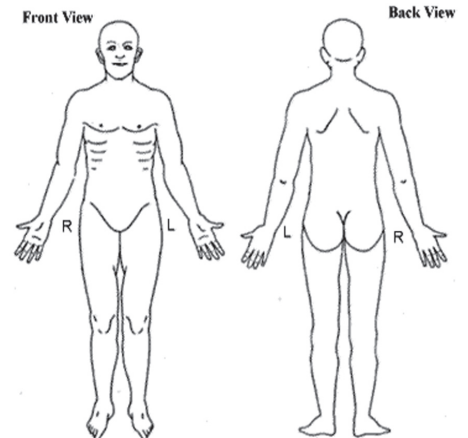
How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: Work _____ Sleep _____ Daily Routine _____ Recreation _____

Check activities or movements that are painful to perform:

Sitting _____ Standing _____ Walking _____ Bending _____ Lying Down _____ Turning _____



Health Information

What treatment have you already received for your condition? Medicines _____ Surgery _____ Physical Therapy _____ Chiropractic Services _____
 None _____ Other _____

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

Date of Last: Physical Examine _____ Spinal X-Ray _____ Blood Test _____
 Spinal Examine _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place ✓ mark on YES or NO to indicate if you have had any of the following:

AIDS/HIV	Yes___ No___	Chicken Pox	Yes___ No___	Liver Disease	Yes___ No___	Rheumatoid Arthritis	Yes___ No___
Alcoholism	Yes___ No___	Diabetes	Yes___ No___	Measles	Yes___ No___	Rheumatic Fever	Yes___ No___
Allergy Shots	Yes___ No___	Emphysema	Yes___ No___	Migraine Headaches	Yes___ No___	Scarlet Fever	Yes___ No___
Anemia	Yes___ No___	Epilepsy	Yes___ No___	Miscarriage	Yes___ No___	Stroke	Yes___ No___
Anorexia	Yes___ No___	Fractures	Yes___ No___	Mononucleosis	Yes___ No___	Suicide Attempt	Yes___ No___
Appendicitis	Yes___ No___	Glaucoma	Yes___ No___	Multiple Sclerosis	Yes___ No___	Thyroid Problems	Yes___ No___
Arthritis	Yes___ No___	Goiter	Yes___ No___	Mumps	Yes___ No___	Tonsillitis	Yes___ No___
Asthma	Yes___ No___	Gonorrhoea	Yes___ No___	Osteoporosis	Yes___ No___	Tuberculosis	Yes___ No___
Bleeding Disorder	Yes___ No___	Gout	Yes___ No___	Pacemaker	Yes___ No___	Tumors, Growths	Yes___ No___
Breast Lump	Yes___ No___	Heart Disease	Yes___ No___	Parkinson's Disease	Yes___ No___	Typhoid Fever	Yes___ No___
Bronchitis	Yes___ No___	Hepatitis	Yes___ No___	Pinched Nerve	Yes___ No___	Ulcers	Yes___ No___
Bulimia	Yes___ No___	Hernia	Yes___ No___	Pneumonia	Yes___ No___	Vaginal Disorders	Yes___ No___
Cancer	Yes___ No___	Herniated Disk	Yes___ No___	Polio	Yes___ No___	Venereal Disease	Yes___ No___
Cataracts	Yes___ No___	Herpes	Yes___ No___	Prostate Problem	Yes___ No___	Whooping Cough	Yes___ No___
Chemical Dependency	Yes___ No___	High Cholesterol	Yes___ No___	Prosthesis	Yes___ No___	Other _____	
		Kidney Disease	Yes___ No___	Psychiatric Care	Yes___ No___	_____	

Place ✓ mark on all which apply:

Exercise	Work Activity	Habits	
None _____	Sitting _____	Smoking _____	Packs/Day _____
Moderate _____	Standing _____	Alcohol _____	Drinks/Week _____
Daily _____	Light Labor _____	Coffee/Caffeine Drinks _____	Cups/Day _____
Heavy _____	Heavy Labor _____	High Stress Level _____	Reason _____

Are you Pregnant? YES _____ NO _____ Due Date _____

Injuries / Surgeries	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications	Allergies	Vitamins / Herbs / Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy Name _____ Pharmacy Phone Number _____