CHIROPRACTIC REGISTRATION AND HISTORY

WELCOME TO OUR OFFICE

PATIENT INFORMATION

Patient Name _____ Preferred Name _____

Street Address _____ City/State/Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail _____

Birthdate _____ Age _____ SSN _____ Sex □ M □ F Marital State □ M □ S □ W □ D

Employer _____ Occupation _____

Employer Address _____

Race (you can check more than one)
□ American Indian/Alaskan Native □ Asian □ Black/African American □ Caucasian/White □ Hispanic
□ Native Hawaiian □ Other □ Decline to specify

Ethnicity
□ Hispanic or Latino □ Non-Hispanic or Non-Latino □ Withheld

Language Preference _____

Spouse/Parent Name _____ Birthdate _____ Occupation _____

Whom may we thank for referring you? _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone _____

PATIENT CONDITION

Major reason for seeking chiropractic care _____

Date symptoms appeared or accident happened _____

Rate you major area of pain on the 0 – 10 rating scale. You are rating your PAIN, not how weak or strong you feel.

1 = Very Weak 10 = Very, Very Strong

Your pain now 1 2 3 4 5 6 7 8 9 10

Your pain on your ***best*** day in the last 30 days 1 2 3 4 5 6 7 8 9 10

Your pain on your ***worst*** day in the last 30 days 1 2 3 4 5 6 7 8 9 10

ACCIDENT INFORMATION

Is your condition due to an accident? □ Yes □ No Date _____

If yes, what type of accident? □ Auto* □ Work** □ Home □ Other

*See receptionist for information regarding our payment/insurance policy
**Please note: This office does not accept Worker's Compensation claims

PAYMENT OPTIONS

Please check the payment option you will be using at this office:
□ Health Insurance □ Medicare □ Personal Injury Protection □ Self Pay (no insurance)

(continued on next page)

MEDICATIONS

What medications or drugs are you taking? _____

_____

Please list any vitamins, herbs, minerals or over-the-counter medications you are taking: _____

_____

HEALTH HISTORY

Date of last physical exam _____

Have you been treated for any health condition by a physician in the last year? □ Yes □ No

If yes, describe: _____

Serious illness and operations (include dates): _____

_____

Accidents/Falls/Serious Injuries (old or recent): _____

_____

Allergies: _____

Exercise: □ None □ Moderate □ Daily □Heavy

Work Activity: □ Sitting □ Standing □ Light Labor □ Heavy Labor

Habits: □ Smoking □ Alcohol □ Coffee/Caffeine Drinks □ High Stress Level

Female patients only: Are you pregnant or is there a possibility you are pregnant? □ Yes □ No

Place a mark on "Yes" or "No" to indicate if you have ever had any of the following health issues/symptoms:

Headaches	□ Yes □ No	Heart Trouble	□ Yes □ No	Constipation/Diarrhea	□ Yes □ No
Dizziness/Fainting	□ Yes □ No	Diabetes	□ Yes □ No	Poor Circulation	□ Yes □ No
Neck Pain/Stiffness	□ Yes □ No	Arthritis	□ Yes □ No	Nervousness	□ Yes □ No
Upper back pain	□ Yes □ No	Asthma	□ Yes □ No	Sinus Trouble	□ Yes □ No
Mid back pain	□ Yes □ No	Neuritis	□ Yes □ No	Tuberculosis	□ Yes □ No
Lower back pain	□ Yes □ No	Hypertension	□ Yes □ No	Anemia	□ Yes □ No
Arm symptoms	□ Yes □ No	Cancer	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Hand symptoms	□ Yes □ No	Lungs	□ Yes □ No	Fatigue	□ Yes □ No
Shoulders	□ Yes □ No	Stomach	□ Yes □ No	High Cholesterol	□ Yes □ No
Hips	□ Yes □ No	Digestive Disorders	□ Yes □ No	Other	□ Yes □ No
Legs	□ Yes □ No	Indigestion	□ Yes □ No		□ Yes □ No
Knees	□ Yes □ No	Liver	□ Yes □ No		□ Yes □ No
Ankles	□ Yes □ No	Gallbladder	□ Yes □ No		□ Yes □ No
Feet	□ Yes □ No	Kidney	□ Yes □ No		□ Yes □ No
Numbness/Tingling	□ Yes □ No	Urinary/Bladder	□ Yes □ No		□ Yes □ No
Cramping	□ Yes □ No	Colon	□ Yes □ No		□ Yes □ No

Anything you wish to add? _____

SIGNATURE AND DATE

Authorization & Release: I authorize payment of insurance benefits directly to Dr. Jeffrey Pedersen/Pedersen Chiropractic Center. I understand and agree to allow this chiropractic office to use my Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operation and coordination of care. I understand that I am responsible for all cost of chiropractic care, regardless of insurance coverage.

Patient Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____