ROCKSIDE CHIROPRACTIC REGISTRATION AND HISTORY

DATE: _____

Name: _____
Last **First** **Middle**

Address: _____

_____
City **State** **Zip**

Marital Status: Single Married Divorced Widowed Minor

Birthdate: _____ **Age:** _____

SSN: _____ **Sex: M F**

Home Phone: _____

Cell Phone: _____

Best number to reach you at: HOME or CELL

Our office has implemented a text/email reminder system. Please provide your cellphone carrier: _____

E-mail:_____

Employer: _____

Work Phone: _____

Spouse: _____

Birthdate: _____

Phone Number: _____

Emergency contact: _____

Emergency contact phone #: _____

Reason for Visit: _____

When did your symptoms appears? _____

Rate your pain 1 (least pain) to 10 (most pain) _____

Type of Pain: Sharp Dull Throbbing Numbness Shooting Burning Tingling Cramps Stiffness Swelling

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

Primary Insurance: _____

Policy Holder's Name: _____

Policy Holder's Birthdate: _____

Relationship to patient: _____

Member ID: _____

Group Number: _____

Is this patient covered by any other insurance? Y N

Secondary Insurance: _____

Policy Holder's Name: _____

Policy Holder's Birthday: _____

Relationship to patient: _____

Member ID: _____

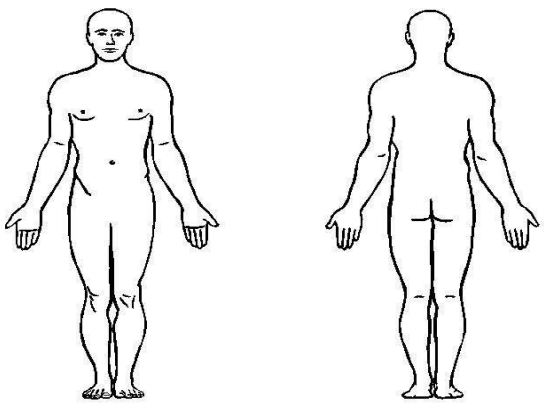
Group Number: _____

ASSIGNMENT AND RELEASE

I request that payment of authorized benefits be made on my behalf. I assign benefits payable directly to **Marc N. Friedman, D.C. / Rockside Chiropractic**. I understand that I am financially responsible for all charges whether or not paid by my 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 all the above named Insurance Companies for the purpose of obtaining benefit information or payment for services rendered.

_____
(Patients Name)

_____
Signature Date



Rockside Chiropractic

HEALTH HISTORY: PLEASE CHECK ALL THAT APPLY

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

_____

_____

Are you Pregnant? Y N

Due Date: _____

Exercise:	**Work Activity:**	**Habits:**	
None	Sitting	Smoking	Packs/ Day_____
Moderate	Standing	Alcohol	Drinks/ Week_____
Daily	Light Labor	Coffee/Caffeine	Cups/Day_____
Heavy	Heavy Labor	High Stress Levels	Reason_____

What treatment have you received for your condition? : None Medications Surgery Physical Therapy Chiropractic Services

Name and Phone Number of other doctors who have treated you for this condition:

_____

Date of Last: Physical/Spinal Exam: _____ Spinal X-Rays_____ MRI/ CT-Scan/ Bone Scan_____

Injuries/ Surgeries: **Description** **Date**

Falls: _____

Head Injuries: _____

Broken Bones/ Dislocations: _____

Surgeries: _____

Medications/Vitamins: **Allergies:**

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____