Patient Registration

Patient Information

Date____

Patient Name:_______________________________________
Last Name

_________________________________ ________________
First Name Middle Initial

Nickname:____

Address:____

City:____

State________________ Zip_______________________

Sex: □ M □ F Age_____________

Birth Date____
□ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered

Occupation____

Employer/School______________________________________

Employer/School Phone (______) ______________________

Spouse's Name_______________________________________

Spouse's Birth Date___________________________________

Spouse's Employer____________________________________

Do you have Children? □No □Yes

How many?__________________________________

How did you hear about us?
□ Internet □ Sign □ Insurance company
□ Referred by ________________ □ Other _____________

Contact Information

Home Phone (_______) ____________________________

Cell Phone (________) ____________________________

Cell Provider______________________________

Email ____
Preferred method of contact: □ Home Phone □ Cell
□ Email □ Text

Best time to reach you ________________________

IN CASE OF EMERGENCY, CONTACT
Name______________________ Relationship______________

Phone (_______) _____________________________________

Financial Information

Who is responsible for this account? __________________________

Will you be using insurance to help pay for your care? □ Yes □No
If yes, please complete the following:

Name of insured person _____________________________________

Relationship to Patient _____________________________________

Insurance Co. ____

Member ID # ____

Is patient covered by additional insurance? □ Yes □ No

Subscriber's Name ____

Birth Date ____

Relationship to patient ______________________________________

Insurance Co. ____

Member ID #____

ASSIGNMENT AND RELEASE

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

____________________________________ and assign directly to
Name of Insurance Company(ies)

Dr. Derek Carroll all insurance benefits, if an, 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.
Dr. Carroll and/or his staff 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 the 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

____
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 □ Worker Comp. □ Other

Attorney name (if applicable) __________________________________

Last:________________________First:__________________________ File #_________

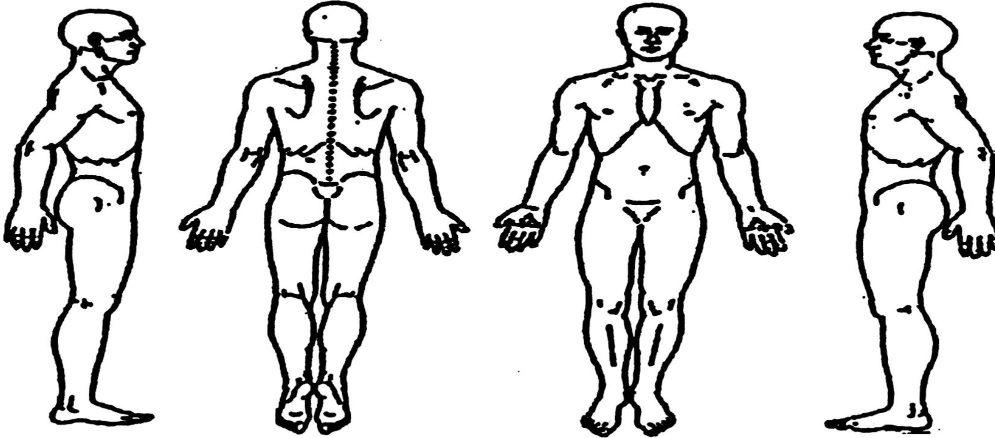
PATIENT INTAKE FORM

Patient Name: ______________________________ Date: _______________

- **Are you here today for: □ Wellness/Health Optimization □ Maintenance/Injury prevention □ An active complaint**
- **If here for an active complaint, please describe** ____

____

1. Indicate on the drawings below where you have pain/symptoms



2. 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)

3. How would you describe the type of pain?
□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:___________________

4. How are your symptoms changing with time?
□ Getting Worse □ Staying the Same □ Getting Better

5. 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*)

6. How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

7. How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____________
□ Massage Therapist □ Physical Therapist □ No one

9. How long have you had this problem? ___________

10. How do you think your problem began?
____

Last:________________________First:__________________________ File #_________

11. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

12. What aggravates your problem?
____

13. What relieves your symptoms?
____

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

15. What is your: Height___________ Weight _____________

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. 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	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Benign Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:____________________________				

- **What medications you are currently taking (including all non-prescription drugs):**
____
- **List any vitamins or supplements you are currently taking:**
____
- **List all surgical procedures you have had:**
____

Last:________________________First:__________________________ File #_________

- **What activities do you do at work/school?**

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Drive:**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Misc:**	□ Do manual labor	□ Read a lot	□ Travel frequently

- **What activities do you do outside of work/school?**
  ____

  ____

- **Have you ever been hospitalized?** □ No □ Yes
  if yes, why ____

- **Have you had any significant past trauma?** □ No □ Yes
  If yes, please describe ____

  ____

- **When was your last chiropractic visit?** ____________________________________
- **Anything else pertinent to your visit today?**___________________________________
- **Please complete the following questions:**
  - If I had 15% better function, I would be able to ______________________________

    ____.
  - If I could do one thing to improve my health, it would mean_______________________

    ____ to me.
  - If I could foster better health in my kids, it would mean ________________________

    ____.
  - The one thing that I want to be able to continue to do from now until the end of my life is
    ____

    ____.

Patient Signature______________________________ **Date:**_________________