Shoreline Family Chiropractic & Wellness Registration & History

Patient Information

Date: _____/____/_____ Whom may we thank for referring you?_____

Patient:_____ D.O.B_____/_____/_____ Age:_____ ☐M ☐F

Address:_____City:_____ State:_____Zip:_____

Height:_____ Weight:_____ Martial Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

Social Security #:_____ Email: _____

Home Phone #:_____ Cell #:_____Work #:_____

Occupation:_____ Employer:_____

Employer Address:_____ City:_____ State:_____Zip:_____

Spouse's Name:_____ Occupation_____ _____D.O.B.:___/____/____

What are the best ways to contact you? ☐ Home☐ Cell☐ Work ☐Text☐ Email ☐Facebook ☐ Other:

IN CASE OF EMERGENCY CONTACT:

Name:_____ Home phone:_____Cell/Work:_____Relationship:_____

Insurance

****Be sure to provide the front desk with ALL health insurance and Photo IDs****

ASSIGNMENT & RELEASE

I, understand, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Shoreline Family Chiropractic 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the signature on all insurance submissions.

_____ _____ _____/_____/_____

Responsible Party Signature Relationship Date

Accident Information

Is this condition due to an accident? ☐**YES** ☐**NO** Type of Accident: ☐**Auto** ☐**Work** ☐**Home** ☐**Other**

Injury Date _____ Auto Insurance Information (if injury related to Auto Accident):

Company:_____ Policy :_____

***Are you pregnant ☐ Yes ☐ No Due Date: _____ Comments: _____**

Chiropractic is the detection and correction of Vertebral Subluxations (spinal mis-alignment that cause disruption to your nervous system) to maintain proper health. Subluxations are caused by physical, chemical, and emotional stressors to the body. Please complete the section below so that we may have a better understanding of your health status and the stress that your body has previously had or currently is experiencing.

Please turn over...

Patient Condition (101-110)

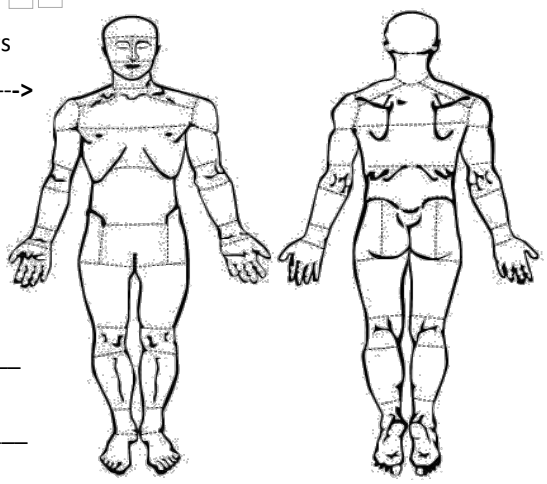
Primary reason(s) for visit: _____

How did this occur?: _____

Symptoms appeared: ☐ Gradually ☐ Suddenly Has this happened before? Y N If yes, When_____

How long have you had this issue? _____ Years / Months / Weeks / Days

Mark an X on the picture to the right where you are having pain or discomfort --->



Type of pain: ☐Aching ☐Burning ☐Diffused ☐Dull ☐Numbness ☐Sharp
☐Shooting ☐Throbbing ☐Tightness ☐Tingling

How frequently do you have this pain? (Check one below):

☐Constant ☐Frequent ☐Intermittent ☐Occasional

Symptoms are aggravated by: _____

Symptoms are reduced by: _____

Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10
(0= no pain 10= worst pain imaginable)

What time of day is the pain most noticeable? _____

DAILY ACTIVITIES (***111)*** What kind of effect does your condition have on the following? Check all that apply.

Bathing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Carrying Groceries	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Climbing Stairs	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Computer Use	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Concentration	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Dressing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Driving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Exercising	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Hobbies	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Household Chores	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Lifting Children	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Pet Care	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Playing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sexual Activities	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sitting / Standing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleep	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Yard Work	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

Family Hx (112) : ☐Cancer ☐Heart Dz ☐Osteoporosis ☐Arthritis ☐Obseity ☐Diabetes ☐Other:

Please list ALL Meds and reason for taking them (113):_____

_____

List Prior Surgeries(114)_____

Exercise:_____Hobbies_____

Glasses of alcohol weekly:_____ Smoking Amount Daily_____Coffee Amount Daily: ____ __ Soda Amount Daily:_____

Any additional information you believe would be helpful for us to know:_____

Please proceed to next page…

Health History " In the past 12 months I have experienced…..

❑Recent accident
❑Muscle Spasms
❑Numbness
❑Tingling
❑Radiating pain
❑Headaches
❑Depression
❑Anxiety
❑Dizziness
❑Vision problems
❑Nausea
❑Restriction movement
❑Sleeping problems
❑Asthma
❑Breathing problems
❑High blood pressure
❑Hearing problems
❑Convulsions
❑Heartburn
❑Acid reflux
❑Digestive problems
❑Menstrual problems
❑Sinus disorder
❑Shoulder problems
❑Hip leg discomfort
❑Jaw/mouth problems

❑Born with bone or joint disorder
❑Degenerative arthritis
❑Rheumatoid arthritis
❑Compression fracture
❑Heart attack
❑History of stroke
❑Cancer
❑Diabetes
❑Gout
❑Lupus
❑Ankylosing spondylitis
❑Immune suppression
❑Use of steroid medications
❑Tuberculosis
❑Hepatitis B or HIV infection
❑Multiple Sclerosis
❑Thyroid or hormone disorder
❑Poor balance
❑Blurred or double vision
❑Memory loss after injury
❑Unexplained weight loss
❑Recent progressive muscle weakness
❑Shaking
❑Recent fever over 103 degrees
❑Loss of bowel or bladder control

❑Neck pain with difficulty swallowing
❑Extreme neck stiffness with pain
❑Shock when moving neck, back, arms or legs
❑Leg pain worsens with exercise
❑Numbness of inner thighs
❑Back pain with urinary problems
❑Severe pain that interrupts sleep
❑Constant pain that doesn't improve by changing position or by lying down

❑**Your CHILDREN/INFANTS**
❑ Colic
❑ Sleep Problems
❑ Ear Infections
❑ Reflux
❑ Bed Wetting
❑ ADD/ADHD
❑ Scoliosis
❑ Allergies / Sinuses
❑ Poor Posture
❑ Traumatic Birth
❑ Headaches or Migraines
❑ Depression
❑ Autism Spectrum Disorder
❑ Lack of Motivation/ Energy
❑ Weight Gain/Loss

Please rate your level of commitment to resolving this condition and improving your health:
0=no commitment **0 1 2 3 4 5 6 7 8 9 10** 10=full commitment

If less than 10, what limits your commitment: □ TIME □ MONEY □ OTHER_____

I rate my health over the past 5 years as: ___Improved ___Same ___Worse

Assuming we can help you, how would you like to address your health?
___ Symptom Relief Only (Does NOT correct the cause of the problem)
___ Maximum Correction (Corrects the cause of the problem, leading to wellness care)

Primary Care Physician:_____ Date of last Exam:_____

Have you received chiropractic care before? YES NO Name of D.C._____Reason For Stopping _____

Date of Last: Spinal Exam:_____ Dental Exam:____Chest X ray:____Urine Test:_____MRI/CAT Scan, Bone Scan: ___

Injuries/Surgeries you have had: LIST ALL with dates: _____

By signing below, I certify that ALL information provided on these forms is true to the best of my knowledge.

Print Name: _____

Signature_____ Date:_____/_____/_____