REGISTRATION AND HISTORY

PATIENT INFORMATION

Date______________

Patient____

Address____

____
City State Zip

E-mail____

Sex: ___M ___F Age_____ Birth date____________

Single Married Widowed Separated Divorced

Patient SS#____

Occupation____

Employer____

Employer Address________________________________

Employer Phone__________________________________

Spouse's Name___________________________________

Birth date________________ SS#________________

Primary MD______________________________________

Clinic Name/Phone_______________________________

Do you give us permission to release your clinical records/status to your primary MD? ___Y ___N

Whom may we thank for referring you?______________

PHONE NUMBERS

Cell__________________ Home__________________

Work__________________ Ext.__________

INSURANCE

Who is responsible for this account?________________

Primary Insurance Co.______________________________

Subscriber's Name__________________________________

Relationship to patient_____________________________

Birth date______________

Secondary Insurance Co.____________________________

Subscriber's Name__________________________________

Relationship to Patient_____________________________

Birth date______________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with:

____

and assigns directly to ***Winters***® Chiropractic & Physical Therapy, Inc. 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 use of this signature on all insurance submissions.

____
Responsible Party Signature

____
Relationship Date

EMERGENCY CONTACT

Name______________________ Relationship________

Cell __________________ Home __________________

Work ____________________ Ext. __________

ACCIDENT INFORMATION

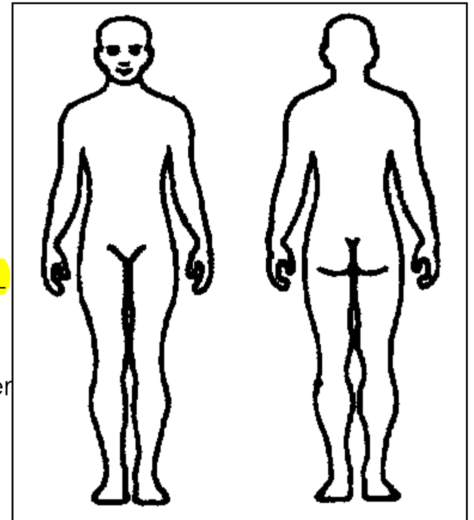
Is this condition due to an accident? ___Yes ___No

If yes, do you currently have a claim open and active? ___Yes ___No

Date of Accident __________

Type of accident? ___Auto ___Work ___Slip & Fall

PATIENT CONDITION



Mark an X on the picture where you continue to have pain.

Reason for visit____

When did your symptoms appear_________________________________

Is this condition getting progressively worse? ___Y ___N ___Unknown

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe)_____

Type of pain? ___Sharp ___Throbbing ___Numbness ___Aching ___Shooting
___Dull ___Burning ___Tingling ___Cramps ___Stiffness ___Swelling ___Other

Is it constant or does it come and go?____________________________

Does it interfere with your? ___Work ___Sleep ___Daily Routine ___Recreation

Activities or movements that are painful to perform. ___Sitting ___Standing ___Walking ___Bending
___Lying down ___Other (explain)_______________________________________

Describe jobs duties (sitting, lifting, etc.) _______________________________________

Have you ever had Chiropractic care for any other problems? ___Y ___N When?______________________

Do you take: ____Muscle Relaxers ____Pain Killers ____Insulin ____Over-the-counter medications
____Other prescription drugs (list all below)

Medications & Milligrams

____
____
____
____

Allergies

____
____
____
____

On average, how many hours of sleep do you get per night? ___________

Do you sleep on your ____Back ____Side ____Stomach

Age of mattress or waterbed _______________ Is your bed comfortable? ___Y ___N

What kind of pillow do you use? ___thick ___medium ___thin ___none ___support

Heath History

Do you wear ___ heel lifts ____ shoe lifts ___ arch supports ____ Orthotics

What treatment have you already received for this condition? ___ None ___Medications ___Surgery ____ Physical Therapy ___ Chiropractic ____ Osteopathy ___ Other ___________

Name of other doctor(s) who have treated you for your condition ______________________

What did they do and/or recommend?____

HEALTH HISTORY CONTINUED

Injuries/surgeries you have had	**Description**	**Date**
Falls ______		
Head injuries ______		
Broken bones ______		
Dislocations ______		
Surgeries ______		

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 Level	Reason______

GENERAL SYMPTOMS Check symptoms you currently have or have had in the **past year**.

General

___bruise easily
___chills
___dental problems
___depression
___difficulty sleeping
___dizziness
___fainting
___fever
___forgetfulness
___headache
___nervousness
___numbness
___sweats
___tiredness

Gastrointestinal

___poor appetite
___bloating/gas
___bowel changes
___constipation
___diarrhea
___excessive hunger
___excessive thirst
___hemorrhoids
___indigestion
___nausea
___stomach pain
___vomiting
___endoscopy
___colonoscopy

Eye, Ear, Nose, Throat

___blurred vision
___crossed eyes
___double vision
___earache
___ear discharge
___hay fever
___hoarseness
___loss of hearing
___ nose bleeds
___persistent cough
___ringing in ears
___sinus problems
___vision-flashes
___vision-halos

Men Only

___breast lump
___erection difficulties
___lump in testicles
___penis discharge
___sore on penis

Women Only

___abnormal pap smear
___bleeding between period
___breast lump
___extreme menstrual pain
__nipple discharge
___painful intercourse
___vaginal discharge

Date of last menstruation
______

Number of children _____

Are you pregnant?
YES NO Not Sure

Have you had a mammogram?
YES NO

Genito-Urinary

___blood in urine
___frequent urination
___lack of bladder control
___painful urination

Cardiovascular

___chest pain
___high blood pressure
___irregular heart beat
___low blood pressure
___rapid heart beat
___swelling of ankles
___varicose veins

SKIN

___ hives
___itching
___changes in moles
___rash
___scars
___sore that won't heal

CONDITIONS Check conditions you have or have had in the **past**.

___AIDS
___alcoholism
___anemia
___anorexia
___appendicitis
___arthritis
___asthma
___bleeding disorders
___breast lump
___bronchitis
___bulimia
___cancer
___cataracts
___chemical dependency
___chicken pox
___diabetes
___emphysema
___epilepsy
___fractures
___glaucom
___goiter
___gonorrhea ___gout
___heart disease
___hepatitis
___hernia
___herpes
___high cholesterol
___HIV positive
___kidney disease
___liver disease
___measles
___migraine headaches
___miscarriage
___mononucleosis
___multiple sclerosis
___mumps
___osteoporosis
___pacemaker
___pneumonia
___polio
___prostate
___prosthesis
___psychiatric disorder
___rheumatoid arthritis
___rheumatic fever
___scarlet fever
___stroke
___suicide attempt
___thyroid problems
___tonsilitis
___tuberculosis
___tumors, growths
___typhoid fever
___ulcers
___vaginal infections
___venereal disease
___whooping cough
___other ___________
____
____
____
____
____

NECK, BACK, EXTREMITIES Check symptoms you currently have or have had in the past **year.**

Neck

___pain in neck
___neck stiffness
___neck weakness
___pinched nerve in neck
___neck feels out of place
___muscle spasms in back
___grinding sounds in neck

Mid-Back

___mid-back pain
___mid-back stiffness
___pain between shoulder blades
___pain from front to back
___low back feels out of place
___muscle spasms in mid back

Low-Back

___low back pain
___low back stiffness
___low back weakness
___pinched nerve in low back
___low back feels out of place
___muscle spasms in low back

Arms and hands	Left	Right	Both
pain in upper arm	___L	___R	___B
pain in elbow	___L	___R	___B
pain in forearm	___L	___R	___B
pain in hand pain	___L	___R	___B
pain in fingers	___L	___R	___B
numbness in arm	___L	___R	___B
numbness in fingers	___L	___R	___B
weakness of arm	___L	___R	___B
weakness of hand	___L	___R	___B
can't raise arm	___L	___R	___B

Hips, Legs, & Feet	Left	Right	Both
pain in buttocks	___L	___R	___B
pain in knee	___L	___R	___B
weakness of knee	___L	___R	___B
pain in ankle	___L	___R	___B
pain in foot	___L	___R	___B
leg cramps	___L	___R	___B
pain down leg	___L	___R	___B
pain in hip	___L	___R	___B

Shoulders	Left	Right	Both
pain in shoulder	___L	___R	___B
pain in shoulder blade	___L	___R	___B
tension in shoulders	___L	___R	___B
pinched nerve in shoulder	___L	___R	___B

Other Symptoms

____
____
____
____
____
____
____
____

Informed Consent for Chiropractic/Physical Therapy Treatment

I, hereby, request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor or chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I see treatment.

TO BE COMPLETED BY PATIENT

Patient's Name________________________________ Signature of Patient__________________________________

Date Signed______________________________

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name________________________________ Signature of Patient__________________________________

Representative's Name___________________________ Signature of Representative__________________________

Relationship or Authority of Patient's Representative__________________________ Date ____________________

TO BE COMPLETED BY DOCTOR OR STAFF

Name of Clinic or Office____

Address____

Name of Doctor(s) treating this patient:

1.____ PIN#____

2.____ PIN#____

3.____ PIN#____