

PATIENT REGISTRATION

Date _____ Home Phone _____ Work Phone _____ Email _____
 Patient Last Name _____ First Name _____ Initial _____
 Street Address _____
 City _____ State _____ Zip _____
 Sex M F Age _____ Birth date _____ Single Married Widowed Separated Divorced
 Social Security # _____ Driver's License # _____
 Insured Name _____ How and where did you learn about this clinic? _____
 Last Name First Name Initial
 Relationship To Insured Self Spouse Child Other
 Condition/ Illness Related To Illness Employment Auto Other

EMPLOYER	Company Name _____ Occupation _____ Address _____ Phone _____ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time City _____ State _____ Zip _____ Years Employed _____
SPOUSE (PARENT)	Name _____ Birthdate _____ SSN: _____ Last Name First Name Initial Employer Name _____ Years Employed _____ Address _____ Phone _____ Occupation _____ City _____ State _____ Zip _____ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured: _____ ID #: _____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured: _____ ID #: _____
MEDICAL AND LEGAL INFORMATION	Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? <input type="checkbox"/> Yes <input type="checkbox"/> No Your Initials: _____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No Family Physician _____ Person to contact in emergency (Name and Phone #) _____ Attorney _____ Telephone: _____ Address _____
Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws	Legal Assignment Of Benefits And Designation Of Authorized Representative In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.
	Signature of Insured / Guardian _____ Date _____

1. The symptom(s) that have prompted me to seek care today include: _____

Patient name _____

2. And are the result of (darken circle): An accident or injury
 Work Auto Other _____
 A worsening long-term problem
 An interest in: Wellness Other _____

3. Onset (When did you first notice your current symptoms?) _____

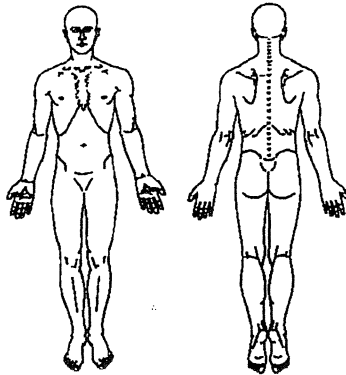
4. Intensity (How extreme are your current symptoms?)
0 10
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)
 Constant Comes and goes. How Often? _____

6. Quality of symptoms (What does it feel like?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other _____

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.) _____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____
What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Surgery Ice
- Over-the-counter drugs Acupuncture Heat
- Homeopathic remedies Chiropractic Other _____
- Physical therapy Massage _____

11. What else should Charles Street Family Chiropractic & Physical Therapy know about your current condition? _____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal

Had Have Osteoporosis Arthritis Scoliosis Neck pain Back problems Hip disorders NONE
 Knee injuries Foot/ankle pain Shoulder problems Elbow/wrist pain TMJ issues Poor posture Initials _____

b. Neurological

Had Have Anxiety Depression Headache Dizziness Pins and needles Numbness NONE
Initials _____

c. Cardiovascular

Had Have High blood pressure Low blood pressure High cholesterol Poor circulation Angina Excessive bruising NONE
Initials _____

d. Respiratory

Had Have Asthma Apnea Emphysema Hay fever Shortness of breath Pneumonia NONE
Initials _____

e. Digestive

Had Have Anorexia/bulimia Ulcer Food sensitivities Heartburn Constipation Diarrhea NONE
Initials _____

f. Sensory

Had Have Blurred vision Ringing in ears Hearing loss Chronic ear infection Loss of smell Loss of taste NONE
Initials _____

g. Skin

Had Have Skin cancer Psoriasis Eczema Acne Hair loss Rash NONE
Initials _____

Consultation Notes

Doctor's Initials _____

Charles Street Family Chiropractic & Physical Therapy

(Continued from previous page)

h. Endocrine

- | | | | | | | |
|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Thyroid issues | <input type="radio"/> Immune disorders | <input type="radio"/> Hypoglycemia | <input type="radio"/> Frequent infection | <input type="radio"/> Swollen glands | <input type="radio"/> Low energy | Initials _____ |

i. Genitourinary

- | | | | | | | |
|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Kidney stones | <input type="radio"/> Infertility | <input type="radio"/> Bedwetting | <input type="radio"/> Prostate issues | <input type="radio"/> Erectile dysfunction | <input type="radio"/> PMS symptoms | Initials _____ |

j. Constitutional

- | | | | | | | |
|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Fainting | <input type="radio"/> Low libido | <input type="radio"/> Poor appetite | <input type="radio"/> Fatigue | <input type="radio"/> Sudden weight gain/loss (circle one) | <input type="radio"/> Weakness | Initials _____ |

Patient name _____

All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

- | | |
|------------------------------------------------------|------------------------------------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> |
| <input type="radio"/> AIDS | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Alcoholism | <input type="radio"/> Typhoid fever |
| <input type="radio"/> Allergies | <input type="radio"/> Ulcer |
| <input type="radio"/> Arteriosclerosis | <input type="radio"/> Other: _____ |
| <input type="radio"/> Cancer | _____ |
| <input type="radio"/> Chicken pox | _____ |
| <input type="radio"/> Diabetes | _____ |
| <input type="radio"/> Epilepsy | _____ |
| <input type="radio"/> Glaucoma | _____ |
| <input type="radio"/> Goiter | _____ |
| <input type="radio"/> Gout | _____ |
| <input type="radio"/> Heart disease | _____ |
| <input type="radio"/> Hepatitis | _____ |
| <input type="radio"/> HIV Positive | _____ |
| <input type="radio"/> Malaria | _____ |
| <input type="radio"/> Measles | _____ |
| <input type="radio"/> Multiple Sclerosis | _____ |
| <input type="radio"/> Mumps | _____ |
| <input type="radio"/> Polio | _____ |
| <input type="radio"/> Rheumatic fever | _____ |
| <input type="radio"/> Scarlet fever | _____ |
| <input type="radio"/> Sexually transmitted disease | _____ |
| <input type="radio"/> Stroke | _____ |

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- Appendix removal
- Bypass surgery
- Cancer
- Cosmetic surgery
- Elective surgery: _____
- _____
- Eye surgery
- Hysterectomy
- Pacemaker
- Spine _____
- _____
- Tonsillectomy
- Vasectomy
- Other: _____
- _____
- _____

16. Treatments

Check the ones you've received in the Past or are receiving Currently.

- | | |
|----------------------------|------------------------------------------------|
| Past <input type="radio"/> | Currently <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> Acupuncture |
| <input type="radio"/> | <input type="radio"/> Antibiotics |
| <input type="radio"/> | <input type="radio"/> Birth control pills |
| <input type="radio"/> | <input type="radio"/> Blood transfusions |
| <input type="radio"/> | <input type="radio"/> Chemotherapy |
| <input type="radio"/> | <input type="radio"/> Chiropractic care |
| <input type="radio"/> | <input type="radio"/> Dialysis |
| <input type="radio"/> | <input type="radio"/> Herbs |
| <input type="radio"/> | <input type="radio"/> Homeopathy |
| <input type="radio"/> | <input type="radio"/> Hormone replacement |
| <input type="radio"/> | <input type="radio"/> Inhaler |
| <input type="radio"/> | <input type="radio"/> Massage therapy |
| <input type="radio"/> | <input type="radio"/> Physical therapy |
| <input type="radio"/> | <input type="radio"/> Nutritional supplements: |

List: _____

- Medications (prescription and over-the-counter): _____

17. Injuries

Have you ever...

- | | |
|------------------------------------------------------|------------------------------------------------------|
| <input type="radio"/> Had a fractured or broken bone | <input type="radio"/> Used a crutch or other support |
| <input type="radio"/> Had a spine or nerve disorder | <input type="radio"/> Used neck or back bracing |
| <input type="radio"/> Been knocked unconscious | <input type="radio"/> Received a tattoo |
| <input type="radio"/> Been injured in an accident | <input type="radio"/> Had a body piercing |

18. Family History

Some health issues are hereditary. Tell Charles Street Family Chiropractic & Physical Therapy about the health of your immediate family members.

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

19. Are there any other hereditary health issues that you know about? _____

20. Social History

Tell Charles Street Family Chiropractic & Physical Therapy about your health habits and stress levels.

- | | | |
|-------------------------------------------------------------------------|-----------------|--------------------------------------------------------------------------|
| Alcohol use <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Prayer or meditation? <input type="radio"/> Yes <input type="radio"/> No |
| Coffee use <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Job pressure/stress? <input type="radio"/> Yes <input type="radio"/> No |
| Tobacco use <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Financial peace? <input type="radio"/> Yes <input type="radio"/> No |
| Exercising <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Vaccinated? <input type="radio"/> Yes <input type="radio"/> No |
| Pain relievers <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Mercury fillings? <input type="radio"/> Yes <input type="radio"/> No |
| Soft drinks <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Recreational drugs? <input type="radio"/> Yes <input type="radio"/> No |
| Water intake <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | |
| Hobbies: _____ | | |

Consultation Notes

Doctor's Initials _____

Charles Street Family Chiropractic & Physical Therapy

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name _____

22. What is the major stressor in your life? _____ 23. How much sleep do you average per night? _____ Hours

24. What is the type and approximate age of your mattress and pillow? _____ 25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Consultation Notes

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

Signature _____

Date (MM/DD/YYYY) _____

Doctor's Initials _____

Charles Street Family
Chiropractic & Physical
Therapy