REGISTRATION

Date: ____________________ Home Phone: ___________________ Cell: _____________________

Name: ______________________________________ Social Security #: ____________________________

Address:_________________________________ City:_________________ State:_________ Zip:___________

Date of Birth: _____________ Age: ________ Height: ________ Weight:__________ Gender: Male / Female

Occupation: ________________ Employer:__________________________ Work Phone #:___________________

Marital Status: ___________ Number of Children: _______________ How old are they? ____________________

Are you a student? ☐ Y ☐ N Where ? ____________________________ Grade Level:_______________________

Referred to this office by: ___________________________ **e-mail**: _______________________________________

Have you ever been treated by a chiropractor before? ☐ Y ☐ N When? __________ Why? ___________________

Emergency contact (Name and Phone #): ____

Present Complaints (Please circle ALL that apply)

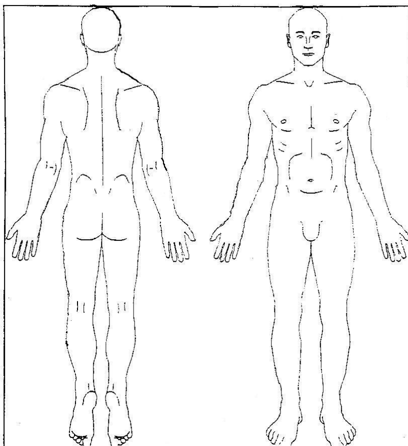
Headache	Feet/Hands Cold	Unbalanced
Mental dullness	Depression	Fainting
Loss of memory	Rib pain	Blurred vision
Dizzy	Nervousness	Irritability
Ears ringing/buzzing	Eye strain/pain	Double vision
Upper back pain	Shortness of breath	Loss of smell
Lower back pain	Fear	Chest pain
Midback pain	Confusion	Neck pain
Pins and needles in hands right/left	Pins and needles in arms right/left	Pins and needles in legs right/left

Medical Implants: ____________________ **Medical alerts:** __________________

Surgical Implants: ____________________ **Pregnancy:** **yes** _____ **no** _____

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Excruciating Pain**



Please circle the areas where you have symptoms on the diagram to the left. Make note of the character of the symptoms using the following abbreviations. Circle all that apply.

S= Sharp **D**= Dull **A**=Achy **N**=Numb **T**=Tingling **B**= Burning

How frequent do you notice your symptoms (circle one):
Constant Frequent Intermittent Occassional

What makes it feel worse: __________________________________

What makes it feel better: _________________________________

When did this condition first appear? _________________________

What do you think caused it? ______________________________

Please circle any of the following CHANGES since the onset of your condition:
Bowel Issues   Bladder Issues   Fever   Night Sweats   Weight Loss   Explain: ___________________________________

Medications: *(please list all medications and supplements that you currently take)*

____________________________	____________________________	____________________________
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________

Allergies: *(please list all medications that cause allergic reaction)*

____________________________	____________________________	____________________________
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________

Smoking: ___ Yes ___ No   If yes, _______ Packs per Day for _____ years

Alcohol ___ Yes ___ No   If yes, Number of drinks per week _________

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery	Date
____	____________________
____	____________________
____	____________________
____	____________________
____	____________________
____	____________________

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

□ asthma	□ pulmonary embolism	□ respiratory arrest
□ COPD	□ pneumonia	□ sleep apnea
□ emphysema	□ tuberculosis	□ other: _____________________

Cardiac / Heart and peripheral vascular disease

□ chest pain / angina	□ high blood pressure	□ irregular heartbeat, arrhythmia
□ heart attack, myocardial infarction	□ heart murmur, valve disorder	□ peripheral vascular disease
□ congestive heart failure	□ mitral valve prolapse	□ deep vein thrombosis
□ other: _____________________	□ bleeding problems	

Neurologic Disorders

□ stroke or TIA	□ parkinson's	□ cerebral palsy
□ peripheral neuropathy	□ MS	□ polio
□ other: _____________________		

Bone & Joint Disorders

□ osteoarthritis	□ gout	□ osteomyelitis
□ rheumatoid arthritis	□ lupus	□ ankylosing spondylitis
□ other: _____________________		

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer	□ diverticulitis	□ hepatitis - Type _______
□ acid reflux, GERD	□ irritable bowel	□ liver disease
□ GI bleed	□ inflammatory bowel disease	□ other: _____________________

Genitourinary Disorders

□ urinary tract infection	□ kidney problems	□ dialysis, kidney failure
□ bladder problems	□ kidney stones	□ other: ______________________

Metabolic & Other Disorders

□ Diabetes x _________ years	□ skin disorder ________________	□ depression
□ thyroid problems	□ psoriasis	□ anxiety
□ sickle cell disease	□ any skin ulcer	□ alcohol or drug dependency
□ high cholesterol or lipids	□ tooth abscess, gingivitis	□ other: ______________________

Cancer : any type -- please specify ____

Other medical problems NOT included above (explain) ____
____
____

Family History:

Please indicate with an "X" any significant family medical history or problems.

□ asthma	□ tuberculosis	□ other lung :______________________
□ COPD or Emphysema	□ sleep apnea	
□ heart attack, myocardial infarction	□ congestive heart failure	
□ irregular heartbeat, arrhythmia	□ bleeding problems	□ other heart :_____________________
□ Peripheral neuropathy	□ MS or Parkinson's	□ other neuro : ____________________
□ osteoarthritis	□ Lupus	□ other bone/joint: ________________
□ rheumatoid arthritis	□ gout	
□ acid reflux, GERD	□ inflammatory bowel disease	□ other GI: _______________________
□ liver disease	□ hepatitis - Type ________	
□ kidney problems	□ dialysis, kidney failure	
□ diabetes	□ psoriasis	□ high cholesterol or lipids
□ thyroid problems	□ sickle cell disease	□ any skin ulcer
□ Malignant hyperthermia		

Cancer : any type -- please specify ____

Other medical problems NOT included above (explain) ____
____
____

Please list **any** other trauma or accidents that you have had. Please include approximate date or your age at the time:

______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________

General Health:

Please rate the **stress level** in your life on a scale of 1-10. 1 2 3 4 5 6 7 8 9 10

No Stress ***High Stress***

In which of the following areas do you experience the **most stress**?

□ Work □ Family □ Children □ Spouse □ Other relationship(s) □ Money □ Health □ Other __________

In your opinion, what is the greatest barrier to being as healthy as you would like?

□ Poor diet □ Lack of exercise □ High stress □ Chronic health condition

□ Environmental toxins □ Physical ailment(s)

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

- ☐ Medicare
- ☐ Blue Cross/Shield
- ☐ Auto Accident
- ☐ Cigna
- ☐ Aetna
- ☐ Union Plan
- ☐ United Health
- ☐ Worker's Compensation
- ☐ Other

Insurance Group Number: ______________________

Insurance Identification Number: ______________________

Medicare Identification Number: ______________________

Primary Care Physician:

Name: ____

Address: ____

Phone #: __________________________

Major Medical or Auto Insurance:

Date of Accident: ______________________________

Insurance Company Name: ______________________________

Adjuster: ______________________________

Address/Phone: ____

Claim #: ___________________ Policy #: _____________________ Effective Date: ______________

LEGAL INFORMATION:

Attorney Name: ____

Attorney Address: ____

Attorney Phone #: ______________________________

Patient Agreement:
ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ____
(Name of Insurance Company)
and assign directly to Dr. David Wright, all medical 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 my insurance submissions.

____ ______________________________
Signature of Insured/Guardian Date