OBERHEIDE CHIROPRACTIC

CHIROPRACTIC REGISTRATION AND HEALTH HISTORY FORM

PATIENT INFORMATION

Patient Name:_____
Date:_____
Social security #:_____
Address:_____
_____
E-mail:_____
Birthdate:_____
( ) Married ( ) Single ( ) Divorced
( ) Widowed ( ) Minor
( ) Partnered for ____ years
Employer/school_____
Employer address_____
_____
Employer phone #_____
Spouse's name:_____
Spouse's employer:_____
Whom may we thank for referring you?_____

INSURANCE INFORMATION

Who is responsible for this account?
_____
SS# of insured _____
Birthdate of insured_____
Relationship to patient _____
Insurance Co. _____
Group #_____ Policy # _____

Assignment and release:

I certify that I, and/or my dependents, have insurance coverage with _____ and assign directly to Dr. Oberheide 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 authorize the use for my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company 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.

X_____
Date:_____

PHONE NUMBERS

Cell _____ Home_____
Best time to reach you_____
Emergency Contact:
Name:_____
Number:_____

ACCIDENT INFORMATION

Is this condition due to an accident?
( ) Yes ( ) No
If yes, please complete personal injury form

PATIENT CONDITION

Reason for visit_____
When did your symptoms appear?_____
Is your condition getting worse over time?_____
Have you seen other doctors for this complaint?_____ Name:_____
Please rate the severity of your pain from 1-10 (10 is the worst pain)_____
Is it constant or does it come and go?_____
How often do you have this pain?_____
Does it interfere with your: ( ) work ( ) sleep ( ) daily routines ( ) recreation
Activities which are painful: ( ) standing ( ) sitting ( ) lying down ( ) walking ( ) bending
Type of pain: ( ) sharp ( ) dull ( ) throbbing ( ) numbness ( ) aching ( ) shooting
( ) burning ( ) tingling ( ) cramps ( ) stiffness ( ) swelling

HEALTH HISTORY

Date of last: Physical Exam_____ Spinal Exam_____
Spinal X-ray_____ Blood/Urine test_____
MRI/CT/bone scan_____

Mark with an X to indicate if you have/had any of the following. Please also mark any that apply to immediate family, and indicate the relationship to you.

AIDS/HIV ( )
Alcoholism ( )
Allergy Shots ( )
Anemia ( )
Anorexia ( )
Appendicitis ( )
Arthritis ( )
Asthma ( )
Bleeding disorders ( )
Breast Lump ( )
Bronchitis ( )
Bulimia ( )
Cancer ( )
Cataracts ( )
Chemical dependency ( )
Diabetes ( )
Emphysema ( )
Epilepsy ( )
Fractures ( )
Goiter ( )
Gout ( )
Heart Disease ( )
Hepatitis ( )
Hernia ( )
Herniated Disc ( )
High Cholesterol ( )
Kidney disease ( )
Liver disease ( )
Migraines ( )
Miscarriage ( )
Multiple Sclerosis ( )
Osteoporosis ( )
Pacemaker ( )
Parkinsons ( )
Polio ( )
Prostate problems ( )
Prosthesis ( )
Psychiatric Care ( )
Stroke ( )
STD ( )
Suicide attempts ( )
Thyroid problem ( )
Tonsillitis ( )
TB ( )
Tumors ( )
Ulcers ( )
Other ( )

Exercise:
( ) none
( ) mild
( ) moderate
( ) heavy

Work Habits:
( ) sitting
( ) standing
( ) light labor
( ) heavy labor

Other Habits:
( ) smoking quantity_____
( ) drinking quantity_____
( ) coffee/caffeine quantity_____
( ) stress reason_____

Pregnancy history: # of pregnancies_____ # of live births_____
# of miscarriages_____ vaginal/C-section?_____ are you pregnant now?_____
If yes, due date?_____

Injuries/Surgeries- Please describe major injuries and any surgical procedures performed: _____
_____

MEDICATIONS	***ALLERGIES***	***SUPPLEMENTS***
Please list medications, what they are for, and how long you have been taking them: 1- 2- 3- 4- 5-	_____ _____ _____ _____ _____ _____ _____ _____ _____	Please list supplements you are currently taking, where you purchased them, and the dose (if known): 1- 2- 3- 4- 5-

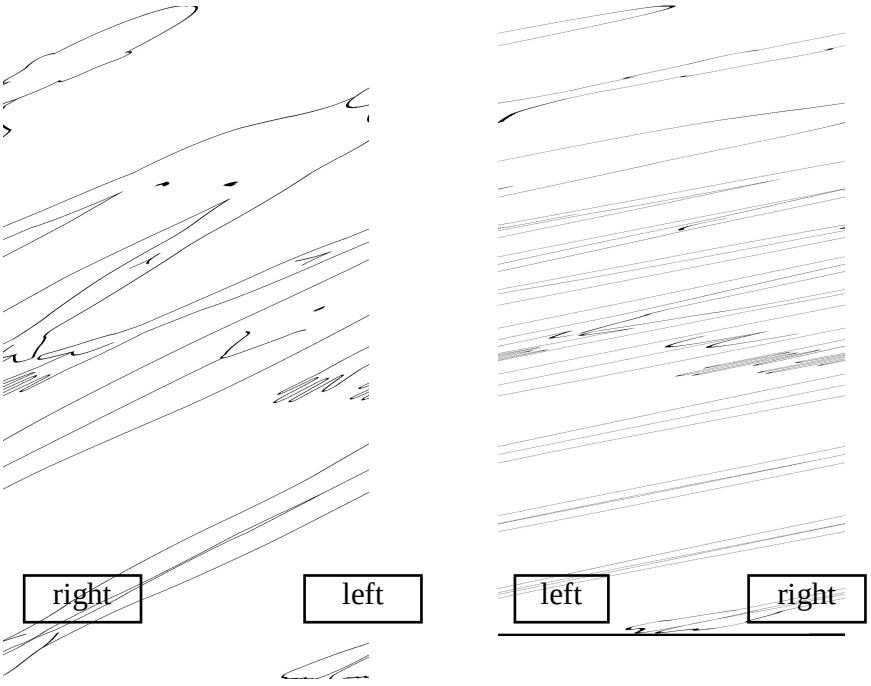
PATIENT GOALS/EXPECTATIONS
Please tell us what your goals/expectations of your care are- ( ) relief care- primary goal is to relieve your symptoms ( ) corrective care- complete the correction begun in the relief care ( ) stabilization- stabilize structures supporting the spine to prevent future episodes ( ) wellness- promotion of optimal functioning of all bodily systems ( ) other: _____

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING
Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000		xxxxx	/ / / / /
- - - - -	00000		xxxxx	/ / / / /
- - - - -	00000		xxxxx	/ / / / /

Please mark on the pain scale from Zero to 10 the pain you feel with this condition.
10 being the worst pain you have felt with this condition.

Pain Chart



Neck-Shoulder-Arm-Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain