Laramie Spinal Care Center
Chiropractic Registration And History

PATIENT INFORMATION

Date _____
SS/HIC/Patient ID# _____
Patient Name _____
Last Name
First Name Middle Initial
Address _____
City _____
State _____ Zip _____
Email _____

Sex ____ M ____ F Age _____
Birthdate _____
____ Married ____ Widowed ____ Single ____ Minor
____ Separated ____ Divorced ____ Partnered (years: ___)

Patient employer/school
Occupation _____
Employer/School address _____
Employer/School phone _____
Spouse's Name _____
Birthdate _____
SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

PHONE NUMBERS

Primary phone _____
Best time and place to reach you _____

IN CASE OF EMERGENCY CONTACT
Name _____ Relationship _____
Best contact phone number _____

ACCIDENT INFORMATION

Is condition due to an accident? ___ Yes ___ No Date _____
Type of accident ___ Auto ___ Work ___ Home ___ Other
To whom have you made a report of your accident?
___ Auto insurance ___ Employer ___ Worker Comp. ___ Other
Attorney Name (if applicable) _____

INSURANCE INFORMATION

Who is responsible for this account _____
Relationship to patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? ____ Yes ____ No
Subscriber's Name _____

Birthdate _____ SS# _____
Relationship to patient _____
Insurance Co. _____
Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of insurance company
Dr. _____ 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 of 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(is) 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 or one year from the date signed below.

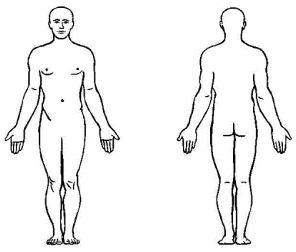
Signature of Patient, Parent, Guardian, or Personal Representative

Please print name of Patient, Parent, Guardian, or Personal Representative

Date Relationship to Patient

PATIENT CONDITION

Reason for visit _____
When did your symptoms appear _____
Is this condition getting progressively worse? ___ Yes ___ No ___ Unknown
Mark an "X" on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____
Type of pain ___ Sharp ___ Dull ___ Throbbing ___ Numbness ___ Aching ___ Shooting
___ Burning ___ Tingling ___ Cramps ___ Stiffness ___ Swelling ___ Other
How often do you have this type of pain? _____
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

HEALTH HISTORY

What treatment have you already received for your condition? ___ Medications ___ Surgery ___ Physical therapy
___ Chiropractic services ___ None ___ Other

Name and address of other doctor(s) who have treated you for your condition _____

Date of last: Physical exam _____ Spinal X-ray _____ Blood test _____
Spinal exam _____ Chest X-ray _____ Urine test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Pinched nerve	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Allergy shots	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Polio	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Heart disease	☐ Yes	☐ No	Prostrate problem	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Psychiatric care	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Herniated disk	☐ Yes	☐ No	Rheumatoid arthritis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No
Bleeding disorders	☐ Yes	☐ No	High blood			Scarlet fever	☐ Yes	☐ No
Breast lump	☐ Yes	☐ No	pressure	☐ Yes	☐ No	Sexually		
Bronchitis	☐ Yes	☐ No	High cholesterol	☐ Yes	☐ No	transmitted		
Bulimia	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No	disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Suicide attempt	☐ Yes	☐ No
Chemical			Migraine headaches	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No
dependency	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chicken pox	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Multiple sclerosis	☐ Yes	☐ No	Tumors, growths	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Typhoid fever	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Fractures	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Vaginal infections	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Parkinson's disease	☐ Yes	☐ No	Whooping cough	☐ Yes	☐ No

Other _____

Exercise
____ None
____ Moderate
____ Daily
____ Heavy

Work Activity
____ Sitting
____ Standing
____ Light labor
____ Heavy labor

Habits
____ Smoking Packs/day _____
____ Alcohol Drinks/week _____
____ Coffee/caffeine drink Cups/day _____
____ High stress level Reason _____

Are you pregnant? ____ Yes ____ No Due date _____

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

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy name _____		
Pharmacy phone		