CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Sex: ☐M ☐F Age _____ Birthdate _____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient SS# _____

Email _____

Occupation _____

Employer _____

Employer Phone _____ ext.

Spouse's Name _____

DOB _____ Occupation _____

Children (names) _____

Past Chiropractic Care? Yes No

When & Results? _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Cell _____ Home _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

MAJOR INJURIES & ACCIDENTS

(broken bones, falls, sports injuries, auto accidents, etc.)

Description Date

_____ _____

_____ _____

_____ _____

_____ _____

MEDICARE

Name on card _____ ID # _____

Do you have a Secondary Yes No

Name _____ ID # _____

INSURANCE

Will you be billing your insurance? Yes No

Company _____ Policy # _____

PATIENT INFORMATION

Reason for visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? _____

Where do 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 Swelling
Burning Tingling Cramps Stiffness Swelling Other _____

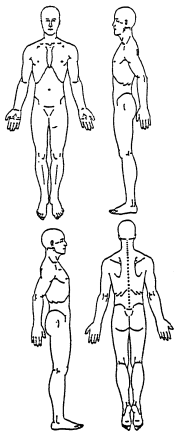
How often do you have this pain? _____

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

What treatment have you already or are presently receiving for your concerns? None Medications Surgery P.T.
Chiropractic Acupucture Other:



Patient/Guardian's Signature _____

Allomong Center of Applied Kinesiology
1225 Ken Pratt Blvd. Suite 137 Longmont, CO 80501
303-827-3772