

# History and Registration

## 1 Patient Information

Date \_\_\_\_\_

Social Security number \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

E-Mail \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex M \_\_\_ F \_\_\_ Age \_\_\_ Marital status M/S/D/W

Birth date \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birth date \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_ PN(\_\_\_\_)

## 2 Insurance Information

Who is responsible for this account? \_\_\_\_\_

Relationship to the Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group# \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Relationship to the Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group# \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to Dr. John Harris 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.

Dr. Harris may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is ended or one year from the date signed below. Dr. Harris will also be granted permission to make a complaint to the Insurance Commissioner for any reason on my behalf.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

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

\_\_\_\_\_  
Date Relationship to Patient

## 3 Phone Numbers

Cell Phone (\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Best time to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

## 4 Accident Information

Is this 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) \_\_\_\_\_

## 5 Patient Condition

Reason for Visit \_\_\_\_\_

When did you first notice your symptoms? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you have pain, numbness, or tingling.

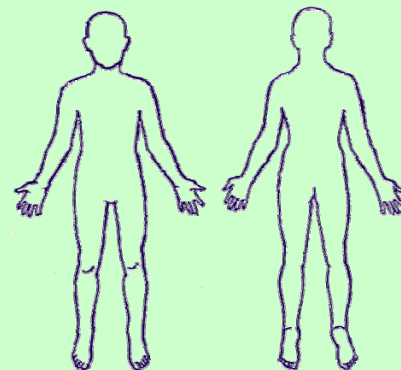
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you get this pain? \_\_\_\_\_ Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities that are painful to perform  Sitting  Standing  Walking  Bending  Lying down



# 6

## Health History

What treatment have you already received for your condition?      Medications      Surgery      Physical Therapy  
 Chiropractic Services      None      Other

Name and address of primary care physician

Please indicate which conditions have been experienced by either, self, mother, or father by marking the appropriate box below.

S = self M= mother F=father

S	M	F		S	M	F	
—	—	—	AIDS	—	—	—	High Blood Pressure
—	—	—	Alcohol		—	—	HIV
—	—	—	Anemia		—	—	Nervousness
—	—	—	Anorexia		—	—	Numbness
—	—	—	Arthritis		—	—	Miscarriage
—	—	—	Asthma		—	—	Multiple Sclerosis
—	—	—	Bladder Trouble		—	—	Osteoporosis

<b>Work Activities</b> <input type="checkbox"/> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/>	<b>Exercise</b> <input type="checkbox"/> <input type="checkbox"/> None <input type="checkbox"/> Moderate (1-2x per week) <input type="checkbox"/>	<b>Habits</b> <input type="checkbox"/> <input type="checkbox"/> Smoking      Packs per Day _____ <input type="checkbox"/> Alcohol      Drinks per _____
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<b>Surgeries/Injuries</b>	<b>Date</b>
Surgeries _____	_____
Car Accidents _____	_____
Falls _____	_____

# 7

## Supplements

## Medications

## Allergies

_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____
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