CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Date:____________________

Patient Name:____________________
Last Name

____
First Name *Middle Initial*

Address:____________________

City:____________ State:______ Zip:______

E-Mail:____________________

Sex ☐M ☐F Age:________ D.O.B.:____________
mm/dd/yyyy

Married ☐ Divorced ☐ Single ☐

Separated ☐ Widowed ☐ Partnered for_____ *years*

Occupation:____________________

Employer/School:____________________

Employer/School Address:____________________

____

Employer/School Phone: (_______)____________

Spouse's Name:____________________

Age:________ D.O.B.:____________

Spouse's Employer:____________________

Whom may we thank for referring you?____________

INSURANCE

☐ COPY OF INSURANCE CARD IN FILE

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with____________ and assign directly to Dr. Mary C. Ramsden all insurance benefits 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. Ramsden may use my health care information for the purpose of obtaining my insurance benefits and payment for services rendered.

Print Name:____________________

Signature:____________________

Date:____________________

PHONE NUMBERS

Home ( )__________ Cell ( )__________

Best time to reach you:____________am/pm

Emergency Contact:____________________

Relationship to patient:____________________

Home ( )__________ Cell ( )__________

Work ( )____________

PATIENT CONDITION

Reason for visit____________________

When did your symptoms appear____________________

Is condition getting progressively worse ☐Yes ☐No

Rate your level of pain on a scale of 1 (least) to 10 (severe):________

☐Sharp ☐Aching ☐Numbness
☐Dull ☐Throbbing ☐Stiffness
☐Burning ☐Cramps ☐Shooting
☐Tingling ☐Swelling ☐Other

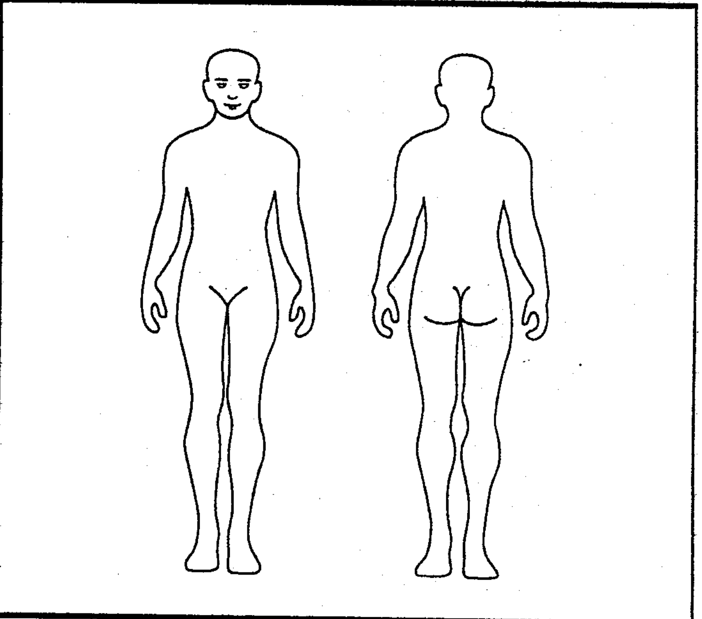
Is this pain constant ☐Yes ☐No

How often do you experience this pain____________

It interferes with ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Activities/movements that are painful : ☐Sitting
☐Standing ☐Walking ☐Bending ☐Lying Down

MARK AN X ON THE PICTURE BELOW WHERE YOU CONTINUE TO HAVE PAIN NUMBNESS OR TINGLING



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