

# BIERBRAUER CHIROPRACTIC

## PATIENT REGISTRATION & HISTORY

### Patient data

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_

Email: \_\_\_\_\_

Telephone (work): (\_\_\_\_) \_\_\_\_\_ (home): (\_\_\_\_) \_\_\_\_\_ Referred by: \_\_\_\_\_

\*Your email will NOT be shared with any 3<sup>rd</sup> parties and is used only for occasional office announcements and promotions unless otherwise requested by you.

### Mailing Address

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_-\_\_\_-\_\_\_\_\_ Social Security #: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Health Status: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### Current Complaints

Nature of Injury:  Automobile\*  Work  Other

Date your symptoms began: \_\_\_/\_\_\_/\_\_\_\_\_

Describe your symptoms: \_\_\_\_\_

How did your symptoms start? \_\_\_\_\_

Have you ever had the same condition?  No  Yes If yes, when? \_\_\_\_\_

Average Pain Intensity: (circle one or a range)

Last 24 Hours: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

Past week: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

How often do you experience your symptoms?

1 – Constantly (76% - 100% of the time) 2 – Frequently (51% - 75% of the time)

3 – Occasionally (26% - 50% of the time) 4 – Intermittently (0% - 25% of the time)

How much have your symptoms interfered with your daily activities?

1 – Not at all 2 – A little bit 3 – Moderately 4 – Quite a bit 5 – Extremely

How is your condition changing, since care at *this* facility?

N/A – This is the initial visit 1 – Much worse 2 – Worse 3 – A little worse

4 – No change 5 – A little better 6 – Better 7 – Much better

In general, would you say your overall health right now is...

1 – Excellent 2 – Very good 3 – Good 4 – Fair 5 – Poor

### Signatures

Name of Insured: \_\_\_\_\_

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_

Spouse's or guardian's signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_

**Medical History**

Have you been treated for any conditions in the last year?  No  Yes If yes, please describe: \_\_\_\_\_

Date of last physical exam: \_\_\_/\_\_\_/\_\_\_\_\_ If female, is there a chance that you are pregnant?  No  Yes

Have you had x-rays taken?  No  Yes If yes, where? \_\_\_\_\_

What medications are you taking and for what conditions (Please list dosage and amounts, etc.) \_\_\_\_\_

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage and frequency). \_\_\_\_\_

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="radio"/>	<input type="radio"/>	_____
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	_____
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	_____
Had sprain/strains?	<input type="radio"/>	<input type="radio"/>	_____
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	_____
Had Surgery?	<input type="radio"/>	<input type="radio"/>	_____

**Family History**

Family Members – Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you experience pain every day?	<input type="radio"/> No <input type="radio"/> Yes
Do your symptoms interfere with daily life?	<input type="radio"/> No <input type="radio"/> Yes
Does pain wake you up at night?	<input type="radio"/> No <input type="radio"/> Yes
Are your symptoms worse during certain times of the day?	<input type="radio"/> No <input type="radio"/> Yes
Do changes in weather affect your symptoms?	<input type="radio"/> No <input type="radio"/> Yes
Do you wear orthotics?	<input type="radio"/> No <input type="radio"/> Yes
Do you take vitamin supplements?	<input type="radio"/> No <input type="radio"/> Yes
What activities aggravate your symptoms? _____	
_____	
_____	

Habits	None	Light	Moderate	Heavy
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee (caffeine)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soft Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salty Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sugary Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial Sweeteners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Have you ever suffered from:**

- AIDS/HIV
- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Back Pain
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold Extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain or Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Menstrual Cycle
- Kidney Infection
- Kidney Stones
- Loss of Memory
- Loss of Balance
- Loss of Smell
- Loss of Taste
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of Breath
- Sinus Infection
- Sleep Problems or Insomnia
- Spinal Curvatures
- Stroke
- Swelling of Ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

**A**=Ache

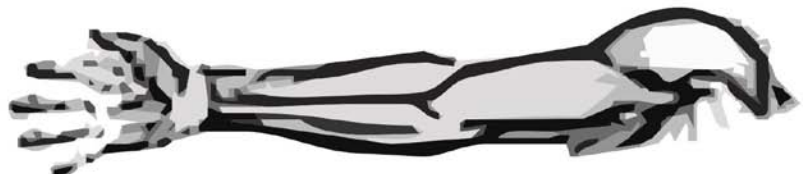
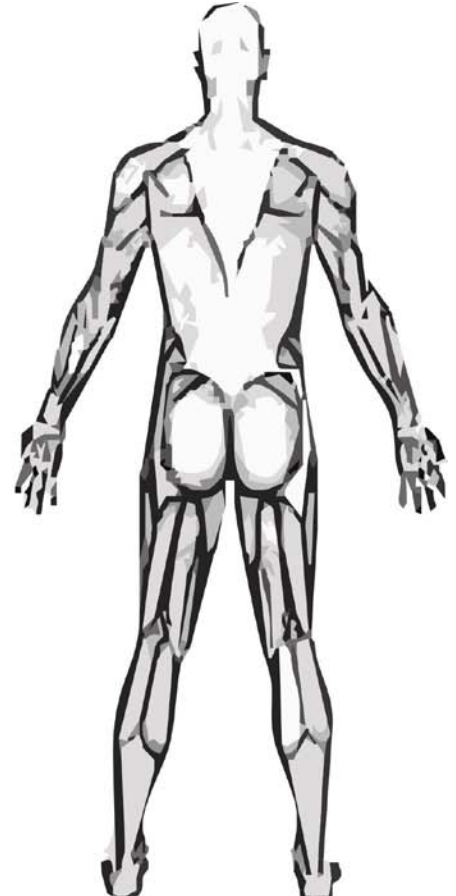
**B**=Burning

**N**=Numbness

**O**=Other

**P**=Pins & Needles

**S**=Stabbing



**INSURANCE AUTHORIZATION AND RELEASE:**

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. **I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.** I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

**The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_