

**FirstChoice Chiropractic & Rehabilitation, pc**

**PATIENT REGISTRATION**

*(To be filled out by patient)*

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Sex: M / F Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

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

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

Employer Address: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In case of emergency, who should be notified: \_\_\_\_\_ Phone: \_\_\_\_\_

**I authorize FirstChoice Chiropractic to: text call email me appointment reminders and/or other messages: Yes No**

**HEALTH INSURANCE INFORMATION**

Is patient covered by additional Health Insurance? Yes No

Insurance Company: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

Subscriber Name: Last: \_\_\_\_\_ First: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Address (if different from above: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**PERMISSION TO DISPLAY**

By my signature below, I hereby give permission for my photo and testimonial to be displayed in the clinic of First Choice Chiropractic and Rehabilitation as well as the internet (our website, You Tube, Facebook and the internet in general). I understand that only my first name will be used.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ (name of insurance company(ies) and assign directly to FirstChoice Chiropractic & Rehabilitation, pc, 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. FirstChoice Chiropractic & Rehabilitation, pc, 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 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

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient, Parent, Guardian or Personal Representative

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

FirstChoice Chiropractic & Rehabilitation, pc

Patient Intake

(To be filled out by patient)

Patient Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

D/Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ D/Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

Type: MVA WC MM CA PI

Location of your Pain: Headache Neck Shoulders Upper back Low Back Arms Legs  
 Other: \_\_\_\_\_

Describe your pain: Sharp Aching Dull Stabbing Burning Throbbing Pulsing  
Other: \_\_\_\_\_

How often is your pain present: Constant Intermittent Occasional  
Other: \_\_\_\_\_

Do you have  numbness in your arms:  right arm  left arm  both  
 tingling in your legs:  right leg  left leg  both  
 radiating pain  
 weakness Other: \_\_\_\_\_

When did your pain start: Immediately Few hours later Next day Few days later  
Other: \_\_\_\_\_

Have you been experiencing pain in any of these areas before this injury? Yes No  
If yes, explain: \_\_\_\_\_

Are you sleeping ok? Yes No If no, why? \_\_\_\_\_

Since the Accident are you feeling: Better Worse Same

Do you feel better in the morning or evening? Morning Evening Same

What position makes the pain better if any: Laying Down Sitting  Changing positions often  
Standing Nothing makes the pain better

What position makes the pain worse if any: Laying down Sitting Standing Bending Lifting  
Walking Reaching Kneeling Squatting Grasping Staying in prolonged positions

What have you tried at home to help: Massage Laying down Hot bath/shower Ice Heat  
Pain Medication Pain Cream Rest Other: \_\_\_\_\_

Did it help? Yes No A little

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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**PATIENT RECORD INTAKE**

(To be filled out by patient)

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

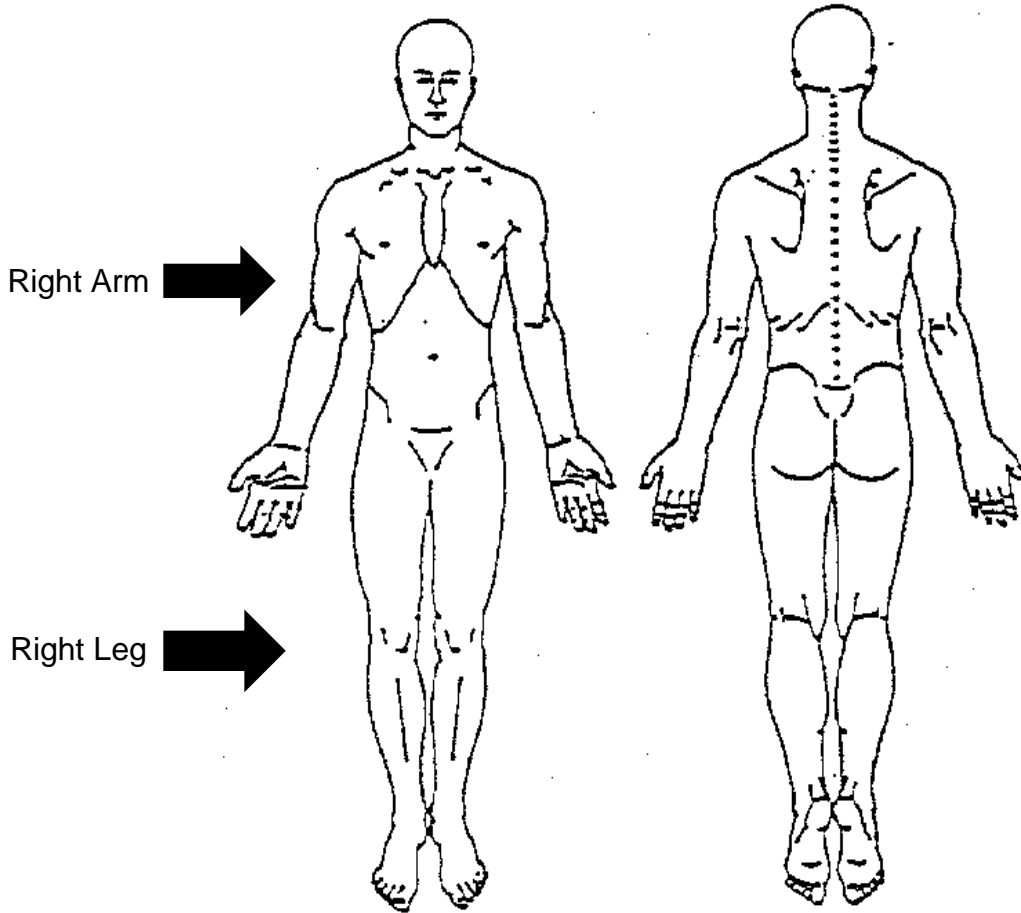
Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

Type: MVA / WC / CA / MM / PI

Please use the following key to accurately mark the figures below in which you feel the described sensation. Use the appropriate symbols and mark all affected areas.

Dull Ache: 1    Stabbing/Cutting: 2    Burning: 3    Numbness: 4    Weakness: 5    Cramping: 6

Tingling (Pins & Needles): 7    Soreness: 8    Tightness: 9    Tense: 10    Spasms: 11



Patients Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Doctor's Signature: \_\_\_\_\_

**FirstChoice Chiropractic & Rehabilitation, pc**  
**Visual Analog Scale (VAS) Intake**  
*(To be filled out by patient)*

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

Type: MVA / WC / PI / MM / CA

Please place one mark on the line below to indicate your present pain level:

Cervical (neck): |-----|

Headaches: |-----|

Thoracic (mid back): |-----|

Lumbar (low back): |-----|

Right/Left Shoulder |-----|

Right/Left Elbow |-----|

Right/Left Wrist |-----|

Right/Left Knee |-----|

Right/Left Ankle |-----|

All Other areas:  
\_\_\_\_\_ |-----|

\_\_\_\_\_ |-----|

\_\_\_\_\_ |-----|

*(The patient was instructed to how mark this VAS form and it was described that the far left side of the line was "no pain" and the far right side was "extreme pain" bad enough that they would have to go to the hospital.)*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Doctor Signature: \_\_\_\_\_

# FirstChoice Chiropractic & Rehabilitation, pc

## HEALTH HISTORY - CONFIDENTIAL

(To be filled out by patient)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Age: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last physical examination: \_\_\_\_/\_\_\_\_/\_\_\_\_

What is your reason for visit today? \_\_\_\_\_

**SYMPTOMS:** (check all symptoms you currently have or have had in the past year)

|  |   |   |   |
|--|---|---|---|
| <p><b>CONSTITUTIONAL</b></p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Forgetfulness</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Loss of sleep</p> <p><input type="checkbox"/> Loss of weight</p> <p><input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Sweats</p> <p><b>MUSCLE/JOINT/BONE</b><br/>Pain, weakness, numbness in:</p> <p><input type="checkbox"/> Arms</p> <p><input type="checkbox"/> Back</p> <p><input type="checkbox"/> Feet</p> <p><input type="checkbox"/> Hands</p> <p><input type="checkbox"/> Hips</p> <p><input type="checkbox"/> Legs</p> <p><input type="checkbox"/> Neck</p> <p><input type="checkbox"/> Shoulders</p> <p><b>GENITO-URINARY</b></p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Lack of bladder control</p> <p><input type="checkbox"/> Painful urination</p> <p><b>ENDOCRINE</b></p> <p><input type="checkbox"/> Loss of hair</p> <p><input type="checkbox"/> Heat/Cold Intolerance</p> <p><input type="checkbox"/> Changes in appetite</p> <p><input type="checkbox"/> Excessive thirst and urination</p> <p><b>PSYCHIATRIC</b></p> <p><input type="checkbox"/> Anxiety / Depression</p> <p><input type="checkbox"/> Mood Swings</p> <p><input type="checkbox"/> Difficulty sleeping</p> | <p><b>GASTROINTESTINAL</b></p> <p><input type="checkbox"/> Appetite poor</p> <p><input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Bowel changes</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Excessive hunger</p> <p><input type="checkbox"/> Excessive thirst</p> <p><input type="checkbox"/> Gas</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Rectal bleeding</p> <p><input type="checkbox"/> Stomach pain</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Vomiting blood</p> <p><b>CARDIOVASCULAR</b></p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Irregular heart beat</p> <p><input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> Rapid heart beat</p> <p><input type="checkbox"/> Swelling of ankles</p> <p><input type="checkbox"/> Varicose veins</p> <p><b>RESPIRATORY</b></p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Coughing Blood</p> <p><input type="checkbox"/> Difficulty Breathing</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Night Sweats</p> <p><input type="checkbox"/> Chills</p> <p><b>HEMATOLOGY/LYMPATIC</b></p> <p><input type="checkbox"/> Easy Bruising</p> <p><input type="checkbox"/> Frequent gums bleeding</p> <p><input type="checkbox"/> Enlarged glands</p> | <p><b>EYE, EAR, NOSE, THROAT</b></p> <p><input type="checkbox"/> Bleeding gums</p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Crossed eyes</p> <p><input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> Earache</p> <p><input type="checkbox"/> Ear discharge</p> <p><input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Loss of hearing</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Persistent cough</p> <p><input type="checkbox"/> Ringing in ears</p> <p><input type="checkbox"/> Sinus problems</p> <p><input type="checkbox"/> Vision - flashes</p> <p><input type="checkbox"/> Vision - halos</p> <p><b>SKIN</b></p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Change in moles</p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Scars</p> <p><input type="checkbox"/> Sore that won't heal</p> <p><b>ALLERGIC/IMMUNOLOGICAL</b></p> <p><input type="checkbox"/> Hives / Eczema</p> <p><input type="checkbox"/> Seasonal allergies</p> <p><input type="checkbox"/> Frequent skin infection</p> <p><input type="checkbox"/> Frequent Runny nose</p> <p><input type="checkbox"/> Hypersensitivity to insect bites</p> | <p><b>NEUROLOGICAL</b></p> <p><input type="checkbox"/> Loss of strength/weakness</p> <p><input type="checkbox"/> Numbness/pins &amp; tingling</p> <p><input type="checkbox"/> Tremors</p> <p><input type="checkbox"/> Memory Loss</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Seizures</p> <p style="text-align: center;"><b>MEN ONLY</b></p> <p><input type="checkbox"/> Breast lump</p> <p><input type="checkbox"/> Erection difficulties</p> <p><input type="checkbox"/> Lump in testicles</p> <p><input type="checkbox"/> Penis discharge</p> <p><input type="checkbox"/> Sore on penis</p> <p><input type="checkbox"/> Other</p> <p style="text-align: center;"><b>WOMEN ONLY</b></p> <p><input type="checkbox"/> Abnormal pap smear</p> <p><input type="checkbox"/> Bleeding between periods</p> <p><input type="checkbox"/> Breast lump</p> <p><input type="checkbox"/> Extreme menstrual pain</p> <p><input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> Nipple discharge</p> <p><input type="checkbox"/> Painful intercourse</p> <p><input type="checkbox"/> Vaginal discharge</p> <p><input type="checkbox"/> Other</p> <p>Date of last menstrual period: _____</p> <p>Date of last pap smear: _____</p> <p>Have you had a mammogram?<br/>( )Yes ( )No</p> <p><b>Are you pregnant?</b><br/>( )Yes ( )No ( )Unsure</p> <p><b>Are you trying?</b><br/>( )Yes ( )No</p> <p>Number of children _____</p> |
|--|---|---|---|

**CONDITIONS:** (check all symptoms you currently have or have had in the past year)

|  |  |   |  |
|--|--|---|--|
| <p><input type="checkbox"/> AIDS</p> <p><input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Anorexia</p> <p><input type="checkbox"/> Appendicitis</p> <p><input type="checkbox"/> Arthritis</p> | <p><input type="checkbox"/> Chemical dependency</p> <p><input type="checkbox"/> Chicken pox</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Glaucoma</p> | <p><input type="checkbox"/> High cholesterol</p> <p><input type="checkbox"/> HIV positive</p> <p><input type="checkbox"/> Kidney disease</p> <p><input type="checkbox"/> Liver disease</p> <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Migraine headaches</p> | <p><input type="checkbox"/> Prostate problem</p> <p><input type="checkbox"/> Psychiatric care</p> <p><input type="checkbox"/> Rheumatic fever</p> <p><input type="checkbox"/> Scarlet fever</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Suicide attempt</p> |
|--|--|---|--|

**FirstChoice Chiropractic & Rehabilitation, pc**

|  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Asthma<br><input type="checkbox"/> Bleeding disorders<br><input type="checkbox"/> Breast lump<br><input type="checkbox"/> Bronchitis<br><input type="checkbox"/> Bulimia<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Cataracts | <input type="checkbox"/> Goiter<br><input type="checkbox"/> Gonorrhea<br><input type="checkbox"/> Gout<br><input type="checkbox"/> Heart disease<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> Hernia<br><input type="checkbox"/> Herpes | <input type="checkbox"/> Miscarriage<br><input type="checkbox"/> Mononucleosis<br><input type="checkbox"/> Multiple sclerosis<br><input type="checkbox"/> Mumps<br><input type="checkbox"/> Pacemaker<br><input type="checkbox"/> Pneumonia<br><input type="checkbox"/> Polio | <input type="checkbox"/> Thyroid problems<br><input type="checkbox"/> Tonsillitis<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Typhoid fever<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Vaginal infections<br><input type="checkbox"/> Venereal disease |
|--|--|---|---|

**MEDICATIONS:** List medications you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY:** Fill in health information about your immediate family: *(To be filled out by patient)*

| Relation | Age | State of Health | Age at Death | Cause of Death | Check if your blood relatives had any of the following: |                      |
|----------|-----|-----------------|--------------|----------------|---|----------------------|
|          |     |                 |              |                | Disease:  | Relationship to you: |
| Father   |     |                 |              |                | Arthritis, Gout   |                      |
| Mother   |     |                 |              |                | Asthma, Hay Fever                                       |                      |
| Brothers |     |                 |              |                | Cancer  |                      |
|          |     |                 |              |                | Chemical Dependency                                     |                      |
|          |     |                 |              |                | Diabetes  |                      |
|          |     |                 |              |                | Heart Disease, Stroke                                   |                      |
| Sisters  |     |                 |              |                | High Blood Pressure                                     |                      |
|          |     |                 |              |                | Kidney Disease  |                      |
|          |     |                 |              |                | Tuberculosis  |                      |
|          |     |                 |              |                | Other   |                      |

**HOSPITALIZATIONS**

Year: \_\_\_\_\_ Hospital: \_\_\_\_\_ Reason for Hospitalization: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PREGNANCIES**

Year of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Complications, if any: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever received a blood transfusion? ( ) Yes ( ) No  
 If yes, please give approximate dates: \_\_\_\_\_

Serious Illness: \_\_\_\_\_ Date: \_\_\_\_\_ Outcome: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HEALTH HABITS** Mark which you use and how much:

\_\_\_\_\_ Caffeine \_\_\_\_\_

\_\_\_\_\_ Tobacco \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_

**OCCUPATIONAL** Mark if your work exposes you to:

\_\_\_\_\_ Stress \_\_\_\_\_ Hazardous Substances

\_\_\_\_\_ Heavy Lifting \_\_\_\_\_ Other: \_\_\_\_\_

**Social History - ADULT:**

1. Drink alcohol:  Yes  No If yes, how much:  Occasionally  Frequently  Daily
2. What activities do you do that are now difficult?  Sports  Housework  Caring for children  Driving  
 Walking  Sitting  Running  Other: \_\_\_\_\_

- MINOR:**
1. What grade is the patient in: \_\_\_\_\_
  2. Activities normally engaged in at school: PE \_\_\_\_\_ Sports \_\_\_\_\_ Other \_\_\_\_\_
  3. Are these activities difficult to perform since injury?  Yes  No If yes, what: \_\_\_\_\_
  4. Has patient missed school:  Yes  No If yes, how many days: \_\_\_\_\_
  5. If minor, who is present with the child? Mother / Father / Other: \_\_\_\_\_

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

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

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Date

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

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