

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: ____/____/____

FirstChoice Chiropractic & Rehabilitation, pc

PATIENT RECORD INTAKE

(To be filled out by patient)

Name: _____ Date: ____/____/____

Date of Birth: ____/____/____

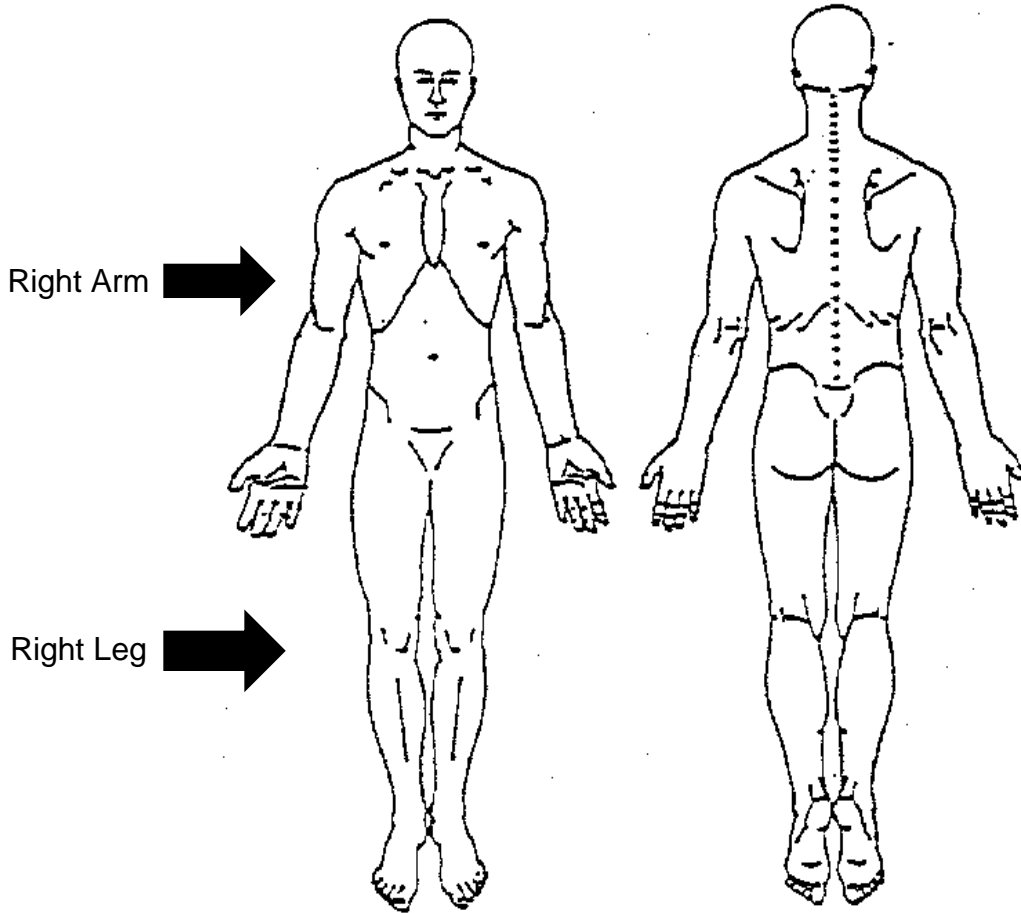
Date of Injury: ____/____/____

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

<p><input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis</p>	<p><input type="checkbox"/> Chemical dependency <input type="checkbox"/> Chicken pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma</p>	<p><input type="checkbox"/> High cholesterol <input type="checkbox"/> HIV positive <input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine headaches</p>	<p><input type="checkbox"/> Prostate problem <input type="checkbox"/> Psychiatric care <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide attempt</p>
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<input type="checkbox"/> Asthma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Breast lump	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Vaginal infections
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Herpes	<input type="checkbox"/> Polio	<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