SPAULDING CHIROPRACTIC CLINIC, INC
REGISTRATION FORM

(Please Print)

Today's date:	Account #

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs. ❑ Ms ❑ Miss	Marital status (circle one) Single / Mar / Div / Sep / Wid

(Maiden name):	Name of Spouse or Significant other :	Driver's License# and State:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

Mailing Address:	City:	State:	Zip Code:

Occupation:	Employer:	Employer Address:	Employer Phone:

Referred by (please check one box): ❑ Currently a Patient ❑ Insurance Plan ❑ Physician/Hospital ❑ Internet ❑ ACS Yellow Pages ❑ Other Yellow Pages ❑ Name of Person/Business:

INSURANCE INFORMATION

(Please give your insurance card(s) and/or information to the receptionist)

Do you have insurance ❑ Yes ❑ No | Auto Accident ❑ Yes ❑ No Date of injury?_____ | Workman's Comp ❑ Yes ❑ No Date of injury? _____

*Name of **Primary** insurance* (health, auto or work comp):	Primary Policyholder's Name and address:	Policy ID or Claim #:	Group #:

Patient's relationship to Primary policyholder: ❑ Self ❑ Spouse ❑ Child ❑ Other

*Name of **Secondary** insurance* (if applicable):	Secondary Policyholder's Name and address:	Policy ID #:	Group #:

Patient's relationship to Secondary policyholder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of Person responsible for bill if not patient:	Responsible Person Birth date: / /	Responsible Person Address (if different):	Responsible Person Home phone : ( )

Is the Responsible Person a patient here? ❑ Yes ❑ No

Responsible Person Employer:	Responsible Person Employer address:	Responsible Person Employer phone: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

PAYMENT POLICY: Patients who carry insurance should remember that services are rendered and charged to the patient and not their insurance company. Any account balance is due by you, the patient, upon receipt of the bill. We bill the insurance company as a courtesy to you. We can not guarantee insurance benefits; it is the patient's responsibility to know their insurance benefits. The office can not accept responsibility for collecting your insurance claim nor for negotiating a settlement on a disputed claim. Returned check charges are $20.00. **PLEASE NOTE**: The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Spaulding Chiropractic Clinic to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

SPAULDING CHIROPRACTIC CLINIC, INC
PATIENT MEDICAL HISTORY

Today's date:	Provider:	Account #

PATIENT INFORMATION

Patient's last name: First: M.I.	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Sex ❑ M ❑ F	Date of Birth :

What is your occupation? _____ Whom may we thank for referring you? _____

Was this injury due to an accident? ❑ Yes ❑ No	What type of accident: ❑ Auto ❑ On the Job ❑ Other

MEDICAL HISTORY

Describe how injury occurred:

What other healthcare have you received for this problem?

Were X-rays taken? ❑ Yes ❑ No Dates of X-rays:

Have you had a similar illness or injury in the past? ❑ Yes ❑ No
Please Explain:

Please list, with dates, any surgery and/or fractures you have had in the past (include any metal or stints):

Have you been treated for any other health condition during the past year? ❑ Yes ❑ No
Please Explain:

What conditions are you taking medications for?

How would you rate your general level of health ❑ Excellent ❑ Good ❑ Fair ❑ Poor

To help the Doctor have better idea of your **GENERAL health** – Please check all that apply:

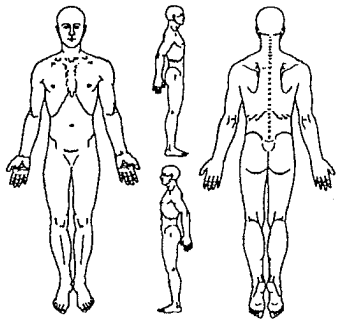
MUSCULO-SKELETAL SYSTEM
- ❑ Low back problems
- ❑ Leg Problems
- ❑ Neck Problems
- ❑ Pain between Shoulders
- ❑ Arm Problems
- ❑ Painful Joints
- ❑ Sore Muscles
- ❑ Weak Muscles
- ❑ Walking Problems

NERVOUS SYSTEM
- ❑ Numbness
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscle Jerking
- ❑ Convulsions
- ❑ Depression

CARDIO-VASCULAR-RESPIRATORY
- ❑ Chest Pain
- ❑ Difficult Breathing
- ❑ Persistent Cough
- ❑ Blood Pressure
- ❑ Heart Problems
- ❑ Lung Problems
- ❑ Varicose Veins

Are you LEFT or RIGHT handed? _____ Your height? _____ Your weight?_____

Place an "X" on areas causing you pain in the drawing below.



What is the area of pain/discomfort? Head Neck Low Back Other (name)

Describe the pain: ❑Dull Ache ❑Cramping ❑Spasms ❑Stabbing ❑Other ❑Burning ❑Numbness ❑Pins & Needles ❑Tingling

What date did the pain begin?

FEMALES ONLY:
Are you pregnant? ❑ Yes ❑ No Ages of Children:
Due Date:
Date of Last Menstrual Cycle:
Any Menstruation Problems?

PERSONAL HABITS

Smoke ❑ Yes ❑ No How Much ____
On a diet ❑ Yes ❑ No How Much ____
Sleep Problems ❑ Yes ❑ No How Much ____
Vitamins? Specify: _____

Alcohol ❑ Yes ❑ No How Much ____
Exercise Daily ❑ Yes ❑ No How Much ____
Drink Water Daily ❑ Yes ❑ No How Much ____

Overweight ❑ Yes ❑ No How Much ____
Extra Stress ❑ Yes ❑ No How Much ____
Coffee ❑ Yes ❑ No How Much ____

CERTIFY : I am aware that there may be a slight risk when receiving Chiropractic Care and providing an accurate medical history is important, therefore I certify that the information I have given is *complete and correct to the best of my knowledge.*

_____ _____
Patient / Guardian Signature ***Date***