

# CHIROPRACTIC REGISTRATION AND HISTORY

Date \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last First Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_M \_\_\_F

\_\_\_Married \_\_\_Single \_\_\_Widowed \_\_\_Minor \_\_\_Separated \_\_\_ Divorced \_\_\_ Partnered for \_\_\_ years

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Best time & place to reach you \_\_\_\_\_

Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Birth date \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

In case of emergency, contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone \_\_\_\_\_ Work Phone \_\_\_\_\_

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

## Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and  
Name of Insurance company(ies)

assign directly to Dr. Sparke 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. Dr. Sparke may use my health care information and may disclose such information to the above-named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance 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

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

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

## Accident Information

Is condition due to an accident? \_\_\_\_\_ Date \_\_\_\_\_

To whom have you make a report of your accident? Auto Insurance \_\_\_ Employer \_\_\_ Worker Comp. \_\_\_

Attorney Name (if applicable) \_\_\_\_\_

**Health History**

What treatment have you already received for your condition? Medications\_\_\_\_ Surgery\_\_\_\_  
Physical Therapy\_\_\_\_ Chiropractic Services\_\_\_\_ None\_\_\_\_ Other\_\_\_\_\_

Name of primary Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_  
Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_  
Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a "Y" or "N" for yes or no to indicate if you have had any of the following:

- |                          |                         |                         |                                  |
|--------------------------|-------------------------|-------------------------|----------------------------------|
| ___ AIDS/HIV             | ___ Diabetes            | ___ Liver Disease       | ___ Rheumatic Fever              |
| ___ Alcoholism           | ___ Emphysema           | ___ Measles             | ___ Scarlet Fever                |
| ___ Allergy Shots        | ___ Epilepsy            | ___ Migraine Headaches  | ___ Sexually Transmitted Disease |
| ___ Anemia               | ___ Fractures           | ___ Miscarriage         | ___ Stroke                       |
| ___ Anorexia             | ___ Glaucoma            | ___ Mononucleosis       | ___ Suicide Attempt              |
| ___ Appendicitis         | ___ Goiter              | ___ Multiple Sclerosis  | ___ Thyroid Problems             |
| ___ Arthritis            | ___ Gonorrhea           | ___ Mumps               | ___ Tonsillitis                  |
| ___ Asthma               | ___ Gout                | ___ Osteoporosis        | ___ Tuberculosis                 |
| ___ Bleeding Disorders   | ___ Heart Disease       | ___ Pacemaker           | ___ Tumors, Growths              |
| ___ Breast Lump          | ___ Hepatitis           | ___ Parkinson's Disease | ___ Typhoid Fever                |
| ___ Bronchitis           | ___ Hernia              | ___ Pinched Nerve       | ___ Ulcers                       |
| ___ Bulimia              | ___ Herniated Disk      | ___ Pneumonia           | ___ Vaginal Infections           |
| ___ Cancer               | ___ Herpes              | ___ Polio               | ___ Whooping Cough               |
| ___ Cataracts            | ___ High Blood Pressure | ___ Prostate Problems   | ___ Other _____                  |
| ___ Chemical             | ___ High Cholesterol    | ___ Psychiatric Care    | _____                            |
| ___ Dependency           | ___ Chicken Pox         | ___ Kidney Disease      | _____                            |
| ___ Rheumatoid Arthritis |                         |                         | _____                            |

**Exercise:** None \_\_\_\_\_ Moderate \_\_\_\_\_ Daily \_\_\_\_\_ Heavy \_\_\_\_\_

**Work Activity:** Sitting \_\_\_\_\_ Standing \_\_\_\_\_ Light Labor \_\_\_\_\_ Heavy Labor \_\_\_\_\_

**Habits:** Smoking \_\_\_\_\_ Packs per day \_\_\_\_\_  
Alcohol \_\_\_\_\_ Drinks per week \_\_\_\_\_  
Coffee/ Caffeine drinks \_\_\_\_\_ Cups per day \_\_\_\_\_  
High Stress Level \_\_\_\_\_ Reason \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ Due Date \_\_\_\_\_

<b>Injuries/ Surgeries you have had</b>	<b>Description</b>	<b>Date</b>
Falls _____		
Head Injuries _____		
Broken Bones _____		
Dislocations _____		
Surgeries _____		

**Medications** \_\_\_\_\_  
Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_

**Allergies** \_\_\_\_\_

**Vitamins/Herbs/Minerals** \_\_\_\_\_