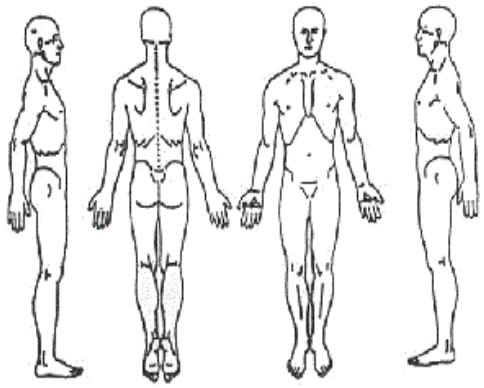
Tilson Chiropractic FamilyCare

New Patient Registration and History

Patient's Name: _____ **Today's Date:** _____

1. Patient Condition



Reason for Visit:_____
When did your symptoms appear? _____
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown
Mark an X on the picture where you continue to have pain, numbness, or tingling
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): ____
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching
☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other
How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down
Is there anything you can do to relieve the problem? ☐ If No, what have you tried?_____
☐ If Yes, describe:_____ What makes the problem worse?_____
Is this condition due to an accident? ☐No ☐Yes Date_____Type of accident ☐Auto ☐ Work ☐ Home ☐ Other
To whom have you made a report of your accident? (Please fill out Vehicle Accident Information/ Worker's Compensation Form)
Auto Insurance ☐ Employer ☐ Worker's Comp. ☐ Other Attorney's Name (if applicable)_____

2. Health History

What treatment have you already received for your condition?
☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____
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 mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes☐ No	Chicken Pox	☐ Yes☐ No	Kidney Disease	☐ Yes☐ No	Rheumatoid Arthritis	☐ Yes☐ No
Alcoholism	☐ Yes☐ No	Diabetes	☐ Yes☐ No	Liver Disease	☐ Yes☐ No	Rheumatic Fever	☐ Yes☐ No
Allergy Shots	☐ Yes☐ No	Emphysema	☐ Yes☐ No	Measles	☐ Yes☐ No	Scarlet Fever	☐ Yes☐ No
Anemia	☐ Yes☐ No	Epilepsy	☐ Yes☐ No	Miscarriage	☐ Yes☐ No	Stroke	☐ Yes☐ No
Anorexia	☐ Yes☐ No	Fractures	☐ Yes☐ No	Mononucleosis	☐ Yes☐ No	Suicide Attempt	☐ Yes☐ No
Appendicitis	☐ Yes☐ No	Glaucoma	☐ Yes☐ No	MS	☐ Yes☐ No	Thyroid Problem	☐ Yes☐ No
Arthritis	☐ Yes☐ No	Goiter	☐ Yes☐ No	Mumps	☐ Yes☐ No	Tonsillitis	☐ Yes☐ No
Asthma	☐ Yes☐ No	Gonorrhea	☐ Yes☐ No	Osteoporosis	☐ Yes☐ No	Tuberculosis	☐ Yes☐ No
Bleeding Disorder	☐ Yes☐ No	Gout	☐ Yes☐ No	Pacemaker	☐ Yes☐ No	Tumors, Growths	☐ Yes☐ No
Breast Lumps	☐ Yes☐ No	Headaches	☐ Yes☐ No	Parkinson's	☐ Yes☐ No	Typhoid Fever	☐ Yes☐ No
Bronchitis	☐ Yes☐ No	Heart Disease	☐ Yes☐ No	Pinched Nerve	☐ Yes☐ No	Ulcers	☐ Yes☐ No
Bulimia	☐ Yes☐ No	Hepatitis	☐ Yes☐ No	Pneumonia	☐ Yes☐ No	Vaginal Infections	☐ Yes☐ No
Cancer	☐ Yes☐ No	Hernia	☐ Yes☐ No	Polio	☐ Yes☐ No	Venereal Disease	☐ Yes☐ No
Cataracts	☐ Yes☐ No	Herniated Disc	☐ Yes☐ No	Prostate Problem	☐ Yes☐ No	Whooping Cough	☐ Yes☐ No
Chem. Depend.	☐ Yes☐ No	Herpes	☐ Yes☐ No	Psychiatric Care	☐ Yes☐ No	Other: _____	

Are you pregnant? ☐ No ☐ Yes, Due Date _____

Please list all injuries/surgeries you have had:	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

3. Lifestyle

Exercise	Work Activity	Habits	Values (Please list your interests in order of importance from 1-8 (1= most important)
☐ None	☐ Sitting	☐ Smoking	____Family ___Financial ___Social
☐ Moderate	☐ Standing	☐ Alcohol	____Mental ___Spiritual ___Work
☐ Daily	☐ Light Labor	☐ Coffee/ Caffeine Drinks	___Physical ___Nutrition
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	

4. Medications

1. _____
2. _____
3. _____
4. _____

Pharmacy Name: _____

Pharmacy Phone: _____

Allergies

1. _____
2. _____
3. _____
4. _____

How often do they occur?

_____

Vitamins/ Supplements

1. _____
2. _____
3. _____
4. _____
5. _____

☐ Daily ☐ Weekly ☐ Monthly

5. Patient Information

Date: _____

Patient Name:

(Last) _____

(First) _____ (MI) _____

Address _____

City _____

State _____ Zip _____

Phone (Cell) _____ (Home) _____

Email _____

Sex: ☐ Female ☐ Male Age _____

Birth Date _____

Social Security No. _____

☐ Married ☐ Single ☐ Partnered for ____ Years

Patient Employer/ School _____

Occupation _____

Employer/ School Address _____

_____

Employer/School Phone _____

7. Emergency Contact

Name _____

Phone (Cell) _____ (Work) _____

Relationship _____

8. Family

Spouse's Name _____

Birth Date _____

Social Security No. _____

Spouse's Employer _____

Children's Name(s)	Sex	Birth Date
_____	M F	_____
_____	M F	_____
_____	M F	_____
_____	M F	_____

9. Referrals

Who may we thank for referring you/ what event did you attend?

_____

6. Insurance Information (Please present insurance card to front desk)

Subscriber's Name _____

Subscriber's Birth Date _____ SSN _____

Relationship to patient _____

Insurance Company _____

Patient ID# _____ Group# _____

This policy is associated with a(n) ☐HSA ☐FSA ☐HRA ☐N/A

Is this patient covered by a secondary insurance?

☐ Yes ☐ No

If Yes, Please fill out the information box below.

Secondary Insurance Information

Subscriber's Name _____

Subscriber's Birth Date _____ SSN _____

Relationship to patient _____

Insurance Company _____

Patient ID# Group#

Assignment and Release

By signing below, I certify that the information on this form is accurate and up- to-date. I certify that I, and/or my dependant(s) have insurance coverage with the aforementioned company(ies) and assign directly to Tilson Chiropractic FamilyCare (TCF) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that 1.) I am financially responsible for any legal fees incurred by TCF for collection efforts of delinquent balances on my and/or my dependent's(s') account(s). I authorize the use of my signature on all insurance submissions. The above-named office may use my healthcare 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. The consent will end when my current treatment plan is completed or one year from the date below.

_____

(Signature of Patient, Guardian or Personal Representative)

_____

(Printed name of Signature of the above)

_____

(Date) (Relationship to Patient)