REGISTRATION AND HISTORY

PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____

City State Zip

E-mail_____

Sex: ___M ___F Age_____ Birth date_____

Single Married Widowed Separated Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birth date_____ SS#_____

Occupation_____

Spouse's Employer_____

Primary MD_____

Clinic Name/Phone_____

Do you give us permission to release your clinical records/status to your primary MD? ___Y ___N

Whom may we thank for referring you?_____

_____

INSURANCE

Who is responsible for this account?_____

Primary Insurance Co._____

Relationship to patient_____

Subscriber's Name_____

Birth date_____

Secondary Insurance Co._____

Relationship to Patient_____

Subscriber's Name_____

Birth date_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with:

_____and assigns directly to ***Winters***® Chiropractic & Physical Therapy, Inc. 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____

Relationship Date

PHONE NUMBERS

Home_____ Work_____ Ext._____

Best time and place to reach you_____

EMERGENCY CONTACT

Name_____ Relationship_____

Home Phone_____ Work phone_____

ACCIDENT INFORMATION

Is condition due to an accident? ___Yes ___No Date_____

Type of accident? ___Auto ___Work ___Home ___Other

To whom have you made a report of your accident? Circle all

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

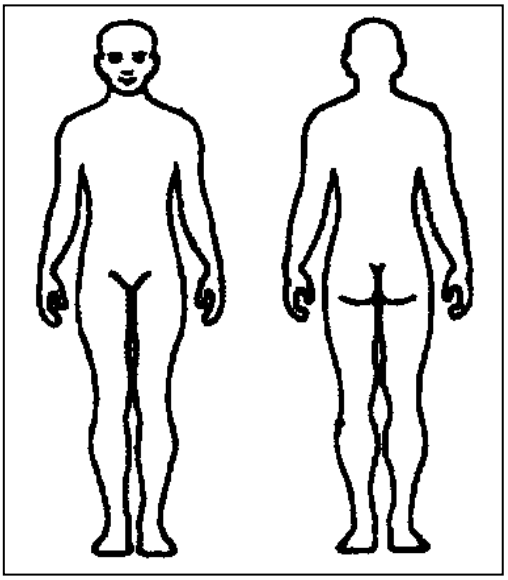
PATIENT CONDITION

Reason for visit_____

When did your symptoms appear_____

Is this condition getting progressively worse? ___Y ___N ___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 of 1 (least pain) to 10 (severe)_____

Type of pain? ___Sharp ___Throbbing ___Numbness ___Aching ___Shooting

___Dull ___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 your? ___Work ___Sleep ___Daily Routine __Recreation

Activities or movements that are painful to perform. ___Sitting ___Standing

___Walking ___Bending ___Lying down ___Other_____

Your Occupation_____

(describe activities-sitting, lifting, etc.)

Have you ever had Chiropractic care for any other problems? ___N ___Y

When?_____

Do you take ___Muscle Relaxers ___Pain Killers ___Insulin ___Birth Control Pills ___Over-the-counter medications

___Other prescription drugs (list all at bottom of page)

Sleep _____ hrs/night Do you sleep on your ___Back ___Side ___Stomach

Age of mattress_____ or waterbed_____ Is your bed comfortable? ___N ___Y

What kind of pillow do you use? ___thick ___medium ___thin ___none ___support

Do you wear ___heel lifts ____ shoe lifts ___arch supports ___ Orthotics, Describe _____

MEDICATIONS & Milligrams	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name		
Pharmacy Phone		

HEALTH HISTORY

What treatment have you already received for your condition?___Medications ___Surgery ___Physical Therapy
___Chiropractic Services _____Osteopathy ___None ___Other_____
Name and address of other doctor(s) who have treated you for your condition_____
What did they do and/or recommend?_____
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_____

HEALTH HISTORY CONTINUED

Injuries/surgeries you have had **Description** **Date**

Falls _____

Head injuries_____

Broken bones_____

Dislocations_____

Surgeries _____

EXERCISE ____hrs/wk	**WORK ACTIVITY**	**HABITS**
___None	___Sitting	___Smoking Packs/Day_____
___Moderate	___Standing	___Alcohol Drinks/Week_____
___Daily	___Light Labor	___Coffee/Caffeine Drinks Cups/Day_____
___Heavy	___Heavy Labor	___High Stress Level Reason_____

GENERAL SYMPTOMS Check symptoms you currently have or have had in the past year.

General

___bruise easily
___chills
___dental problems
___depression
___difficulty sleeping
___dizziness
___fainting
___fever
___forgetfulness
___headache
___loss of sleep
___loss of weight
___nervousness
___numbness
___sweats
___tiredness
___weight gain

Genito-Urinary

___blood in urine
___frequent urination
___lack of bladder control
___painful urination

Gastrointestinal

___appetite poor
___bloating
___bowel changes
___constipation
___diarrhea
___excessive hunger
___excessive thirst
___gas
___hemorrhoids
___indigestion
___nausea
___rectal bleeding
___stomach pain
___vomiting
___vomiting blood

Cardiovascular

___chest pain
___high blood pressure
___irregular heart beat
___low blood pressure
___poor circulation
___rapid heart beat
___swelling of ankles
___varicose veins

Eye, Ear, Nose, Throat

___bleeding gums
___blurred vision
___crossed eyes
___difficulty swallowing
___double vision
___earache
___ear discharge
___hay fever
___hoarseness
___loss of hearing
___ nose bleeds
___persistent cough
___ringing in ears
___sinus problems
___vision-flashes
___vision-halos

SKIN

___bruise easily
___ hives
___itching
___changes in moles
___rash
___scars
___sore that won't heal

Men Only

___breast lump
___erection difficulties
___lump in testicles
___penis discharge
___sore on penis
___other

Women Only

___abnormal pap smear
___bleeding between period
___breast lump
___extreme menstrual pain
___hot flashes
___nipple discharge
___painful intercourse
___vaginal discharge
___ other

_____
Date of last menstruation

_____
Date of last pap smear

_____
Have you had a mammogram?
Number of children_____
Are you pregnant?_____

CONDITIONS Check conditions you have or have had in the past.

___AIDS
___alcoholism
___anemia
___anorexia
___appendicitis
___arthritis
___asthma
___bleeding disorders
___breast lump
___bronchitis
___bulimia
___cancer
___cataracts
___chemical dependency
___chicken pox
___diabetes
___emphysema
___epilepsy
___fractures
___glaucoma
___goiter
___gonorrhea
___gout
___heart disease
___hepatitis
___hernia
___herpes
___high cholesterol
___HIV positive
___kidney disease
___liver disease
___measles
___migraine headaches
___miscarriage
___mononucleosis
___multiple sclerosis
___mumps
___osteoporosis
___pacemaker
___pneumonia
___polio
___prostate
___prosthesis
___psychiatric disorder
___rheumatoid arthritis
___rheumatic fever
___scarlet fever
___stroke
___suicide attempt
___thyroid problems
___tonsilitis
___tuberculosis
___tumors, growths
___typhoid fever
___ulcers
___vaginal infections
___venereal disease
___whooping cough
___other_____
_____

NECK, BACK, EXTREMITIES Check symptoms you currently have or have had in the past year.

Neck
___pain in neck
___neck stiffness
___neck weakness
___pinched nerve in neck
___neck feels out of place
___muscle spasms in back
___grinding sounds in neck

Shoulders	**Left**	**Right**
pain in shoulder joint	___L	___R
___pain across shoulders		
can't raise arm		
above shoulder level	___L	___R
over head	___L	___R
tension in shoulders	___L	___R
pinched nerve in shoulder	___L	___R

Mid-Back
___mid-back pain
___mid-back stiffness
___pain between shoulder blades
___pain from front to back
___muscle spasms in mid back

Arms and hands	**Left**	**Right**
pain in upper arm	___L	___R
pain in elbow	___L	___R
pain in forearm	___L	___R
pain in hand	___L	___R
pain in fingers	___L	___R
pins and needles in arms	___L	___R
pins and needles in fingers	___L	___R
numbness in arm	___L	___R
numbness in fingers	___L	___R
weakness of arm	___L	___R
weakness of hand	___L	___R
hands cold	___L	___R

Low-Back
___low back pain
___low back stiffness
___low back weakness
___pinched nerve in low back
___low back feels out of place
___muscle spasms in low back

Hips, Legs, & Feet	**Left**	**Right**
pain in buttocks	___L	___R
pain in hip joint	___L	___R
pain down leg	___L	___R
pain in knee	___L	___R
pain in ankle	___L	___R
pain in foot	___L	___R
weakness of leg	___L	___R
weakness of knee	___L	___R
leg cramps	___L	___R

Other Symptoms
_____
_____
_____
_____

Informed Consent for Chiropractic/Physical Therapy Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor or chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I see treatment.

TO BE COMPLETED BY PATIENT

Patient's Name_____ Signature of Patient_____

Date Signed_____ Witness or Patient's Signature_____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name_____ Signature of Patient_____

Date Signed_____Signature of Representative_____

Relationship or Authority of Patient's Representative_____

Translated by_____ Date _____

TO BE COMPLETED BY DOCTOR OR STAFF

Name of Clinic or Office_____
Address_____

Name of Doctor's treating this patient:

1._____ PIN#_____

2._____ PIN#_____

3._____ PIN#_____