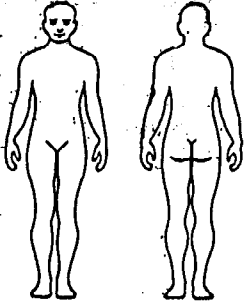


Chiropractic Registration and History

Patient Information	
Date _____	
Patient Name _____	
Address _____	
City _____ State _____ Zip _____	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birthdate _____	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	
Patient SS# _____	
Occupation _____	
Employer _____	
Employer Address _____	
Spouse Name _____	
Birthdate _____ SS# _____	
Occupation _____	
Employer _____	
Whom may we thank for referring you? _____ _____	
Phone Numbers	
Home _____ Work _____ ext _____	
Best time and place to reach you _____	
In Case of Emergency, Contact	
Name _____	
Relationship _____	
Home _____ Work _____ ext _____	

Insurance	
Assignment and Release	
I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Henderson Chiropractic & Sports Rehab, P.C. 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.	
I certify that the information on this sheet is correct to the best of my knowledge.	
Patient/Responsible Party Signature _____	
Relationship _____	Date _____
Email Address Information	
Please check one of the following:	
<input type="checkbox"/> email monthly newsletters/appointment reminders	
<input type="checkbox"/> email outstanding bills/balances to me	
<input type="checkbox"/> I do not have an email/do not email me	
Email Address: _____	

Patient Condition	
Reason for Visit _____	
When did your symptoms/complaints appear? _____	
Is this condition getting progressively worse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Rate the severity of your pain on a scale from 0 (no pain) to 10 (severe pain) _____	
Type of pain: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Throbbing <input type="checkbox"/> Numbness <input type="checkbox"/> Aching <input type="checkbox"/> Shooting	
Mark an X on the picture where you have pain, numbness, tingling, etc.	
How often do you have this problem? <input type="checkbox"/> 1 x daily <input type="checkbox"/> 2 or more x daily <input type="checkbox"/> 1 x weekly <input type="checkbox"/> 2 or more x weekly <input type="checkbox"/> other _____	
Is it: <input type="checkbox"/> Constant <input type="checkbox"/> Come and Go <input type="checkbox"/> Other _____	
Does it interfere with your <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily Routine <input type="checkbox"/> Recreation	
Activities or movements that are painful to perform <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Bending <input type="checkbox"/> Lying Down	

Health History

What treatment(s) have you already received for your present condition(s)? If any, please list below

None Medications Chiropractic Physical Therapy Surgery Other _____

Injuries/Surgeries/Treatments you have had	Description	Date
Medications _____		
Chiropractic Treatment _____		
Physical Therapy _____		
Surgeries _____		
Other _____		

Previous Injuries History	Vitamins/Herbs/Minerals You Take	Allergies
Falls _____	_____	_____
Broken Bones _____	_____	_____
Dislocations _____	_____	_____
Head Injuries _____	_____	_____

Name and address of other doctor (s) who have treated you for your condition(s) /complaint(s) _____

Date of Last: Physical Exam _____ Spinal X-ray _____ Blood Test _____
 Spinal Exam _____ Chest X-ray _____ Urine Test _____
 MRI / CT / Bone Scan _____ For what reason _____

Place a mark either "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growth <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No	Polio <input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disc <input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Coughing <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____
Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No	Measles <input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No		

Exercises	Work Activity	Habits	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	Packs/Day _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	Drinks/Week _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine Drinks	Cups/Day _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress Level	Reason _____

*Females Only * Are you pregnant? Yes No Due Date _____

Patient's Name: _____

The Back/Neck Bournemouth Questionnaire

The following scales have been designed to find out about your back/neck pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your back/neck pain?
No pain
0 1 2 3 4 5 6 7 8 9 10
Worst pain possible
2. Over the past week, how much has your back/neck pain interfered with your daily activities (house work, washing, dressing, and walking, climbing stairs, getting in/out of bed/chair)?
No interference
0 1 2 3 4 5 6 7 8 9 10
Unable to perform activity
3. Over the past week, how much has your back/neck pain interfered with your ability to take part in recreational, social, and family activities?
No interference
0 1 2 3 4 5 6 7 8 9 10
Unable to perform activity
4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?
Not at all anxious
0 1 2 3 4 5 6 7 8 9 10
Extremely anxious
5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?
Not at all depressed
0 1 2 3 4 5 6 7 8 9 10
Extremely depressed
6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back/neck pain?
Have made it no worse
0 1 2 3 4 5 6 7 8 9 10
have made it much worse
7. Over the past week, how much have you been able to control (reduce/help) your back/neck pain on your own?
Completely control it
0 1 2 3 4 5 6 7 8 9 10
No control whatsoever

Patient's signature _____ Date _____