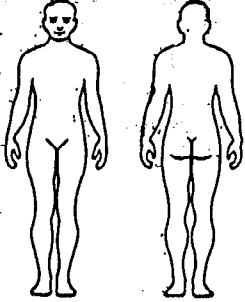


Chiropractic Registration and History

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	