CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____
City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birthdate_____ SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?_____

_____

2 INSURANCE

Insurance Co. 1_____

ID # or Claim #_____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Insurance Co. 2_____

Birthdate_____ SS#_____

Relationship to Patient_____

ID #_____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr. Tajuga_____ 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 give permission to the doctor to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and / or treatment of my condition.

_____ _____
Responsible Party Signature Date

3 PHONE NUMBERS

Email:

Home_____ Work_____ Ext____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Home Phone_____ Work Phone_____

4 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?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)_____

5 PATIENT CONDITION

Reason for Visit_____

When did your symptoms appear?_____

What is your history with this injury? ☐ Sudden Trauma ☐ Reoccurrence ☐ Repetitive Trauma

The pain is . . . ☐ Constant ☐ Intermittent — Lasts for _____ min. hrs. days weeks

How long have you been having pain? ☐ 1 week or less ☐ 1-6 weeks ☐ 6 weeks - 3 months ☐ 3 months - 1 year ☐ > 1 year

How many times have you had the same type pain in the same area? ☐ Never ☐ 1-3 episodes ☐ 4+ episodes

When did you first have these or similar symptoms? ☐ Never ☐ < 6 months ago ☐ 6-12 months ago ☐ >1 year ago

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Bending

Is this condition getting worse? ☐ Yes ☐ No ☐ Unknown

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ None

- OVER -