

CONNECTICUTchiropractic

Amy Person, DC

NEW PATIENT REGISTRATION

Please print clearly to help avoid billing errors

Patient Last Name _____ First _____ MI _____

Mailing Address _____ Apt or Unit # _____

City _____ State _____ Zip _____

Home Telephone () _____ Cell Number () _____ Work # () _____

Date of Birth / / Age _____ Social Security # - - Email Address _____

Marital Status: Single Married Divorced Other Sex: Male Female

Employment Status: Employed Full Time Employed Part Time Full Time Student Unemployed Retired

GUARANTOR NAME
(Person to Bill if Other Than Patient) _____

Mailing Address _____ Apt or Unit # _____

City _____ State _____ Zip _____

Assignment and Release: *I hereby authorize and direct my insurance benefits to be paid directly to Amy Person, DC and I understand I am financially responsible for any and all non-covered services provided by Amy Person, DC.*

Signature: _____ Date _____

Below for Office Use Only

DIAGS: (1) _____ (2) _____ (3) _____ (4) _____

INITIAL VISIT PROCEDURES

DOS: _____ Amt Paid This Visit: \$ _____ Date of Current Illness:(Anth & MC Only) _____

New Exam: 9920 _____	9894 _____ <i>Manip.</i>	97110 _____ <i>Thera Ex.</i>	97112 _____ <i>Neuro Re-Ed</i>	97140 _____ <i>Trigger Point</i>
98943 _____ <i>Extra-Spinal</i>	97010 _____ <i>H/C Packs</i>	97014 _____ <i>E-Stim / Un</i>	97012 _____ <i>Mech. Track</i>	97035 _____ <i>Ultrasound</i>

Check Box To Block Pt. Statements

Name _____ Date _____ File _____

CASE HISTORY

There is room on this page to list 2 different areas of complaint. If you have more than 2 areas of complaint, please ask for more forms.

COMPLAINT AREA 1

What is your current condition or problem?		Onset of problem?	Suddenly / Gradually
What caused the problem?		Date started?	
What makes the problem feel worse?			
What makes the problem feel better?			
How is the problem described?	Achy / Burning / Cold / Fatigue / Hot / Numb / Pins & Needles / Sharp / Tense / Weak / Other:		
Where is the primary site of the problem?			
Where does the problem refer to?	(For instance: Neck pain that refers to the right arm.)		
How often do you notice the problem?	Come and Go / Constant	When is the problem noticed?	Morning / Afternoon / Night
Other associated symptoms?			
What is the status of the condition?	Improving / Same / Worsening	Explain:	

COMPLAINT AREA 2

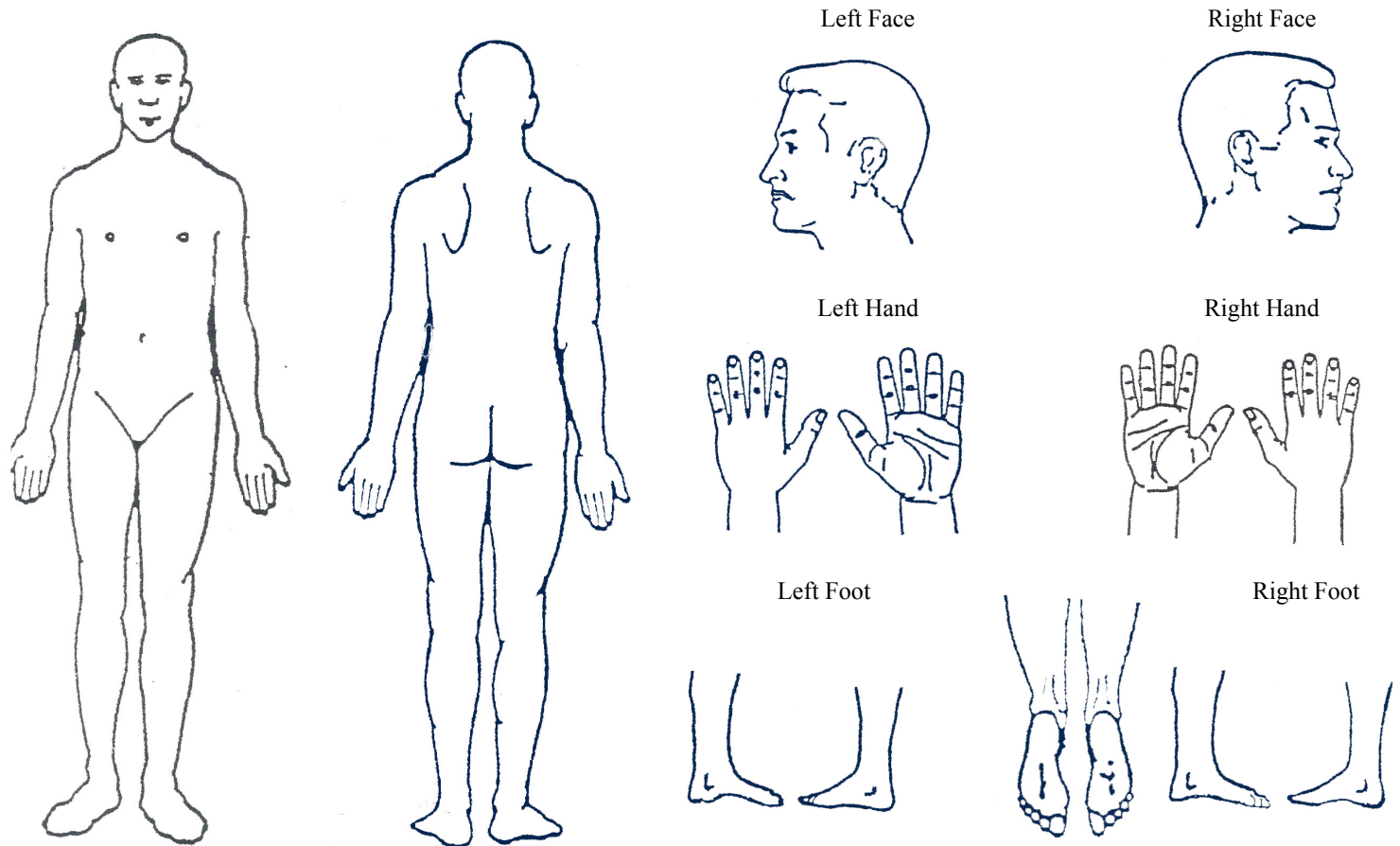
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Where does the problem refer to?	(For instance: Neck pain that refers to the right arm.)		
How often do you notice the problem?	Come and Go / Constant	When is the problem noticed?	Morning / Afternoon / Night
Other associated symptoms?			
What is the status of the condition?	Improving / Same / Worsening	Explain:	

Name _____ Date _____ File _____

Symptom Drawing

Mark the areas on your body where you feel the following sensations.

Aches	^^ ^^	Cramping	CCCC	Pins & Needles	PNPN	Stabbing	////
Burning	XXXX	Numbness	++++	Sensitive	SSSS	Other	OOOO



Rate the severity of your symptom(s) by marking "I" at the appropriate point on the line & grade the symptom from 0 to 10

(Example: 0 _____ I _____ 10)
 No Symptoms 5 Worst Possible, Unbearable

- | | |
|---------------------------------------|------------|
| () Rate your head symptom(s) now | 0 _____ 10 |
| () Rate your neck symptom(s) now | 0 _____ 10 |
| () Rate your mid back symptom(s) now | 0 _____ 10 |
| () Rate your low back symptom(s) now | 0 _____ 10 |
| () Rate your arm symptom(s) now | 0 _____ 10 |
| () Rate your leg symptom(s) now | 0 _____ 10 |

Name _____ Date _____ File _____

PAST HISTORY & SYSTEM REVIEW

Circle for PAST (P) or CURRENT (C) diseases, conditions or symptoms. Then explain in the description section on the next page.

Childhood			Cardiovascular			Genitourinary		
Chicken Pox	P	C	Heart Disease	P	C	Bladder disease	P	C
Measles	P	C	Arteriosclerosis	P	C	Kidney disease	P	C
Rubella	P	C	Murmur	P	C	Stones	P	C
Other	P	C	Stroke	P	C	Urinary tract infections	P	C
Constitutional			Varicose veins	P	C	Urination problems	P	C
Addiction (alcohol, smoke, etc.)	P	C	Arm &/or leg swelling	P	C	Urinate times per day	P	C
Habits (alcohol, smoke, etc.)	P	C	Chest pain / pressure / discomfort	P	C	Male Reproductive		
Eating Disorder	P	C	Cold hands &/or feet	P	C	Discharge. mass, sores, pain	P	C
General fatigue / weakness	P	C	High or low blood pressure	P	C	Prostate disease	P	C
Fever / chills	P	C	High cholesterol	P	C	Testicular disease	P	C
Eyes			Leg pains or cramps	P	C	Sexually transmitted disease	P	C
Cataract	P	C	Palpitations	P	C	Female Reproductive		
Glaucoma	P	C	Respiratory			Discharge. mass, sores, pain	P	C
Tears – excess or reduced	P	C	Lung disease	P	C	Ovary disease	P	C
Vision problems	P	C	Asthma	P	C	Uterus disease	P	C
Ears			Emphysema	P	C	Sexually transmitted disease	P	C
Ear infections / earaches	P	C	Pneumonia	P	C	Menstrual symptoms	P	C
Hearing loss	P	C	Chronic cough	P	C	Menstrual cycle # days		
Ringing	P	C	Difficult breathing / tightness	P	C	Birth Control	P	C
Nose			Gastrointestinal			Pregnancies		
Loss of smell	P	C	Esophagus disease	P	C	Deliveries		
Nasal discharge	P	C	Stomach disease	P	C	Musculoskeletal		
Nasal stuffiness	P	C	Gall bladder disease	P	C	Arthritis	P	C
Sinus			Liver disease	P	C	Braces, Supports, Orthotics	P	C
Sinusitis / infection	P	C	Intestinal disease	P	C	Gout	P	C
Polyps	P	C	Appendicitis	P	C	Muscle pain, swelling, tightness	P	C
Pain	P	C	Hemorrhoids	P	C	Joint pain, swelling, tightness	P	C
Mouth			Hernia	P	C	Neck pain	P	C
Dental disease	P	C	Peptic Ulcer	P	C	Mid-back pain	P	C
Gum disease	P	C	Bowel movement changes	P	C	Low back pain	P	C
Jaw click or mal-position	P	C	Bowel movement times per day			Neurological		
Loss of taste	P	C	Gas / belching / gripping	P	C	Neurological disease	P	C
Saliva – excess or reduced	P	C	Heartburn / constriction	P	C	Concentration problems	P	C
Grinding	P	C	Indigestion / nausea	P	C	Convulsions, seizures	P	C
Throat			Jaundice	P	C	Dizziness / fainting	P	C
Tonsil disease	P	C	Stools bloody / dark	P	C	Headache	P	C
Infections	P	C	Regurgitation / vomiting	P	C	Memory problems	P	C
Swollen glands	P	C	Blood			Migraine	P	C
Difficult swallowing	P	C	Anemia	P	C	Neuritis	P	C
			Bruise / bleed easy	P	C	Sleep problem (# hours)	P	C

Name _____ Date _____ File _____

PAST HISTORY & SYSTEM REVIEW (Continued)

Circle for PAST (P) or CURRENT (C) diseases, conditions or symptoms. Then explain in the description section on the next page.

Integument (Skin)			Endocrine			Any Other Conditions		
Skin disease, rashes, sores	P	C	Endocrine gland disease	P	C		P	C
Eczema	P	C	Thyroid disease	P	C		P	C
Dryness	P	C	Diabetes	P	C		P	C
Psychological			Osteoporosis	P	C		P	C
Mental Illness	P	C	Appetite – excess or reduced	P	C		P	C
Depression	P	C	Sweating – excess or reduced	P	C		P	C
Mood swings	P	C	Temperature intolerance	P	C		P	C
Nervousness	P	C	Thirst – excess or reduced	P	C		P	C
Breasts			Weight change	P	C		P	C
Breast disease	P	C	Immunity				P	C
Discharge	P	C	Allergies	P	C		P	C
Lumps or dimpling	P	C	Cancer	P	C		P	C
Pain or discomfort	P	C	Cold sore	P	C		P	C
Self exam	P	C	Frequent colds	P	C		P	C
			Lyme's disease	P	C		P	C

Name _____ Date _____ File _____

DESCRIPTION OF PAST AND / OR CURRENT CONDITIONS

CONDITION	AGE	PAST CONDITION(S) BRIEFLY DESCRIBE (include – medicine, surgery, chiropractic, etc.)
CONDITION	AGE	CURRENT CONDITION(S) BRIEFLY DESCRIBE (include – medicine, surgery, chiropractic, etc.)

IMMUNIZATION HISTORY

Describe immunizations received over the past year:

HEALTH SCREENING HISTORY

Indicate the last time you were examined or screened for the following. (Leave blank if never, question mark if Date is unknown.)

Exam	Date	Exam	Date	Exam	Date	Exam	Date
History & Physical		Blood Pressure		Stool		Bone Density	
Breast		Pap Smear		Sigmoidoscopy		Body Composition	
Pelvic		Cholesterol		Mammogram		Diet	
Rectal		Venereal Disease		Prostrate		Exercise	
Hearing		PPD (TB)		Posture & Spine		Other:	

Results:

Name _____ Date _____ File _____

DIETARY AND MEDICATION STATUS

DIETARY HABITS AND SOURCES

Describe your dietary habits: (# of meals, vegetarian, quantity of junk food, favorite foods, etc.)

Indicate the frequency of consuming foods from the following sources:

Grocery Store (Home)	Never	Rarely	Often	Usually	Always
Restaurant - Regular	Never	Rarely	Often	Usually	Always
Restaurant – Fast (McDonalds, Wendy’s, etc.)	Never	Rarely	Often	Usually	Always

MEDICINES, SUPPLEMENTS

List all current medicines, nutrients, herbs, botanicals consumed

PHYSICAL ACTIVITY STATUS

Describe your physical activity level: (Low, medium, high – play, TV, computer, rest, sports, exercise, etc.)

HEALTH CARE PROVIDERS

List Health Care Providers currently seen for your current problem(s) and any condition.

Name, Address & Phone	Last Visit	Diagnosis	Treatment
1.			
2.			
3.			
4.			