BREITBACH CHIROPRACTIC REGISTRATION AND HEALTH HISTORY

PATIENT INFORMATION

Date ________ / ________ / ________
Patient Last Name ______________________________
Patient First Name ______________ Middle Initial __
Address ____________________________________
City, State, Zip ______________________________
Email Address ______________________________
____ Male ____ Female Age _______
Birth Date ________ / ________ / ________
Marital Status:
___ Married ___ Single ___ Divorced
___ Partnered ___ Separated ___ Minor
Patient Employer/School ______________________
Employer/School Address ______________________
____
Occupation __________________________________
Employer/School Phone (______) _______________
Spouse Name ________________________________
Spouse Birthdate ________ / ________ / ________
Spouse Employer ______________________________
Whom may we thank for referring you to us?
____

PHONE NUMBERS

Home Phone (______) _______________________
Best time to call this number ___________________
Cell Phone (______) ________________________
Best time to call this number ___________________

IN CASE OF EMERGENCY, WE MAY CONTACT

Name ______________________________________
Relationship to Patient _______________________
Home Phone (_______) ______________________
Work Phone (_______) ______________________
Cell Phone (_______) _______________________

INSURANCE INFORMATION

Name of insured person ________________________
Birth Date ________ / ________ / ________
SS # ______________________________________
Relationship to Patient _________________________
Insurance Company Name _______________________
____
Group # ____________________________________

Additional Insurance Company Name _____________
____
Subscriber Name _____________________________
Birthdate ________ / ________ / ________
Relationship to Patient _________________________
Group # ____________________________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above company(ies) and assign directly to Dr. Breitbach all insured 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 authorize the use of my signature on all insurance submissions.

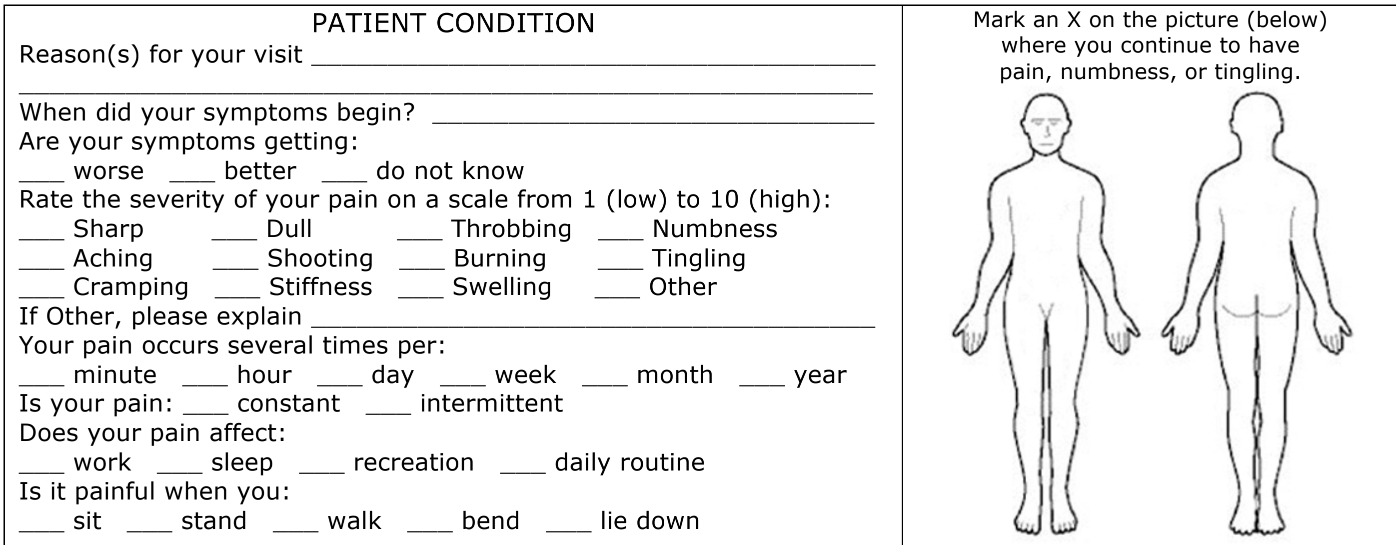
Dr. Breitbach may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is or one year from the date signed below.

____
↑ Printed name of Patient or Guardian ↑

____
↑ Signature of Patient or Guardian ↑

Date ________ / ________ / ________

Relationship to Patient _________________________



PATIENT CONDITION

Reason(s) for your visit ______________________________
____
When did your symptoms begin? _______________________
Are your symptoms getting:
___ worse ___ better ___ do not know
Rate the severity of your pain on a scale from 1 (low) to 10 (high):
___ Sharp ___ Dull ___ Throbbing ___ Numbness
___ Aching ___ Shooting ___ Burning ___ Tingling
___ Cramping ___ Stiffness ___ Swelling ___ Other
If Other, please explain _______________________________
Your pain occurs several times per:
___ minute ___ hour ___ day ___ week ___ month ___ year
Is your pain: ___ constant ___ intermittent
Does your pain affect:
___ work ___ sleep ___ recreation ___ daily routine
Is it painful when you:
___ sit ___ stand ___ walk ___ bend ___ lie down

Mark an X on the picture (below) where you continue to have pain, numbness, or tingling.

ACCIDENT INFORMATION

Is your pain and condition due to an accident? ___ No ___ Yes, date of accident ______ / ______ / ________
Type of accident ___ Auto ___ Work ___ Home ___ Other ______________________________
Did you make a report to: ___ Auto Ins. ___ Employer ___ Worker Comp. ___ None ___ Other ________
Attorney Name (if applicable) ____

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CURRENT AND PAST HEALTH CONDITIONS

Have you received any of the following for your current pain and condition? ___ Medications ___ Surgery
___ Physical Therapy ___ Chiropractic Services ___ Nothing Other ___________________________________
Name and address of other doctor(s) who treated your current condition __________________________________
____

What was the date of your last:
Physical Exam ___________ Spinal X-Ray ___________ Blood Test ___________ Spinal Exam ___________
Spinal Exam ____________ Chest X-Ray ___________ Urine Test ___________ Dental X-Ray ___________
MRI, CT-Scan, Bone Scan ___________

Do you currently have, or have you ever had any of the following health conditions (please circle):

AIDS/HIV	Y	N	Diabetes	Y	N	Liver Disease	Y	N	Rheumatoid Arthritis	Y	N
Alcoholism	Y	N	Emphysema	Y	N	Measles	Y	N	Rheumatic Fever	Y	N
Allergy Shots	Y	N	Epilepsy	Y	N	Migraine Headaches	Y	N	Scarlet Fever	Y	N
Anemia	Y	N	Fractures	Y	N	Miscarriage	Y	N	Sexually Transmitted Disease	Y	N
Anorexia	Y	N	Glaucoma	Y	N	Mononucleosis	Y	N	Stroke	Y	N
Appendicitis	Y	N	Goiter	Y	N	Multiple Sclerosis	Y	N	Suicide Attempt	Y	N
Arthritis	Y	N	Gonorrhea	Y	N	Mumps	Y	N	Thyroid Problems	Y	N
Asthma	Y	N	Gout	Y	N	Osteoporosis	Y	N	Tonsillitis	Y	N
Bleeding Disorders	Y	N	Heart Disease	Y	N	Pacemaker	Y	N	Tuberculosis	Y	N
Breast Lump	Y	N	Hepatitis	Y	N	Parkinson's Disease	Y	N	Tumors, Growths	Y	N
Bronchitis	Y	N	Hernia	Y	N	Pinched Nerve	Y	N	Typhoid Fever	Y	N
Bulimia	Y	N	Herniated Disk	Y	N	Pneumonia	Y	N	Ulcers	Y	N
Cancer	Y	N	Herpes	Y	N	Polio	Y	N	Vaginal Infections	Y	N
Cataracts	Y	N	High Blood Pressure	Y	N	Prostrate Problem	Y	N	Whooping Cough	Y	N
Chemical Dependency	Y	N	High Cholesterol	Y	N	Prosthesis	Y	N	Other:	Y	N
Chicken Pox	Y	N	Kidney Disease	Y	N	Psychiatric Care	Y	N	Other:	Y	N

Have you ever had any of the following? When? Please describe.
___ Falls: ____
___ Head Injuries: ____
___ Broken Bones: ____
___ Dislocations: ____
___ Surgeries: ____

EXERCISE	WORK ACTIVITY	HABITS	STRESS LEVEL
___ none	___ sitting	___ smoking # packs per day ___	___ very high
___ 1-3 times per week	___ standing	___ alcohol # drinks per week ___	___ high
___ 4-6 times per week	___ light labor	___ caffeine # drinks per day ___	___ moderate
___ daily	___ heavy labor		___ light

Are you pregnant? ___ No ___ Yes, due date is _________ / _________ / _________

Preferred Pharmacy ____ Phone (_______) ____________________

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
________________________	________________________	________________________
________________________	________________________	________________________
________________________	________________________	________________________

I, ____, certify that the information on this form is complete and accurate to the best of my knowledge.
↑ Print Name of Patient or Guardian ↑

____ _________ / _________ / _________
↑ Signature of Patient or Guardian ↑ Date

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