CONFIDENTIAL PATIENT REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date: _____

Name: _____
Last Name First Name Initial

Address: _____

_____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

E-mail Address: _____

Sex: □ M □ F Age: _____ Birth date:_____

□ Single □ Married □ Divorced □ Widowed

Social Security #: _____

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone #: _____

Hours / Week Worked: _____

IN CASE OF AN EMERGENCY, CONTACT

Name:_____ Relation: _____

Phone #:_____

Is condition due to an accident? □ Yes □ No

Type of accident / injury:

□ Auto *(Complete Section **3** Below)*

□ Work / Home / Other *(Complete Section **4** on the next page)*

How did you hear about us? _____

2 INSURANCE INFORMATION

Health Insurance *(Primary)*

Ins Co.: _____ Phone:_____

Policyholder name:_____

Relationship to policyholder:_____

Policy #: _____ Group#:_____

Health Insurance *(Secondary)*

Ins Co.: _____ Phone:_____

Policyholder name:_____

Relationship to policyholder:_____

Policy #: _____ Group#:_____

Complete the following if injury is related to an auto accident.

Motor Vehicle Insurance *(Your PIP Info)*

Owner of vehicle in which you were injured:

_____

Ins Co.: _____ Phone:_____

Policy #: _____

Claim #: _____

Have you retained an attorney? □ Yes □ No

Name: _____ Phone:_____

Third Party Information *(Other vehicle that struck yours)*

Name: _____ Phone:_____

Ins Co.: _____ Phone:_____

Policy #: _____ Claim #:_____

3 Auto ACCIDENT INFORMATION *(IF APPLICABLE)*

Date of Injury:_____ Time:_____ AM/PM State: □ DC □ MD □ VA □ PA □ Other _____

Describe in DETAIL how your injury occurred: _____

_____

_____

Were you the: □ Driver □ Passenger Were you sitting in the: □ Front Seat □ Back Seat

Were you struck from: □ Behind □ Front □ Left Side □ Right Side Were you wearing a seatbelt? □ Yes □ No

Did you know you were going to be hit? □ Yes □ No Did you brace for impact? □ Yes □ No

Approximate speed your vehicle was traveling _____mph *OR* were you stopped? □ Yes □ No

Approximate speed the other vehicle(s) were traveling _____mph

Make & Model of your vehicle:_____ Make & Model of other vehicle:_____

Were police notified? □ Yes □ No Did the police file a report? □ Yes * □ No

**** If yes, you must provide a copy of this report to this office within 5 business days of today's date.***

What was the approximate damage to vehicle: □ Minimal □ Moderate □ Extensive □ Totaled

Amount of Damage: $_____ Was your vehicle towed from the scene? □ Yes □ No

4 Work *(or Other)* Injury Information *(If Applicable)*

Date of Injury:_____ Time:_____ AM/PM State: □ DC □ MD □ VA □ PA □ Other _____

Describe in DETAIL how your injury occurred: _____

_____

_____

_____

_____

_____

_____

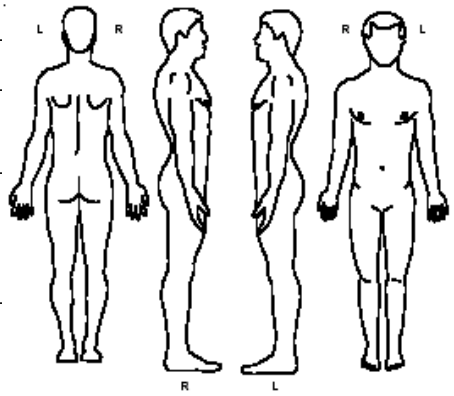
_____

_____

5 Current Complaints

What are your present complaints? *(location of pain, etc.)* _____

_____



Use an "X" on the drawing to mark where you are experiencing pain *(or other symptoms)*.

When did these symptoms first appear? _____

Do your symptoms interfere with: □ Sleep □ Daily routine □ Work □ Recreation

Are you working less hours / days as a result of your injuries? □ Yes □ No

If yes, please explain _____

Activities or movements that are painful to perform:

□ Sitting □ Standing □Walking □ Bending □ Lying Down

How would you rate your symptoms: □ Mild □ Moderate □ Severe

How would you rate your current symptoms (pain): □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

No Symptoms Worst Possible

Since the accident *(if applicable)*, are your symptoms: □ Improving □ Unchanged □ Worsening

6 Hospitalization / Examination History

Have you been to the hospital for *this* condition? □ Yes □ No If yes, name of hospital? _____

When did you go? _____ How did you get there? □ Ambulance □ Self □ Others

Were x-rays taken? □ Yes □ No If yes, what area(s)? _____

Were you prescribed any medication? □ Yes □ No If yes, what medications? _____

Have you seen any other doctor or received any other treatment for your current condition? □ Yes □ No

If yes, explain _____

Doctor's name and address: _____

Phone #: _____ Date(s) seen: _____ Diagnosis: _____

DIAGNOSTIC TESTING YOU MAY HAVE RECEIVED: (place "X" in boxes that apply)

Test	Region / Body Part(s)	Date(s)	Test	Region / Body Part(s)	Date(s)
□ Examination	_____	_____	□ EMG / NCV	_____	_____
□ MRI / CT	_____	_____	□ _____	_____	_____

7 HEALTH HISTORY / INJURIES / TREATMENTS

INJURIES YOU MAY HAVE HAD IN THE PAST Description Date (s)

Auto Accident (s) _____ _____

Work Injuries _____ _____

Broken Bones _____ _____

Other _____ _____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING OR SUFFERING FROM: ***(place "X" in boxes that apply)***

☐ Muscle disorder	☐ Lungs, Asthma	☐ Osteoarthritis
☐ Nervous System Disorder	☐ Broken Bones	☐ Epilepsy
☐ Bone Disorder	☐ Eating Disorder	☐ Alcoholism
☐ Rheumatoid Arthritis	☐ Pace Maker	☐ Drug Addiction
☐ Allergies	☐ Seizures/Convulsions	☐ Strokes
☐ HIV	☐ A Congenital Disease	☐ Cancer
☐ Gallbladder	☐ Excessive Bleeding	☐ Ulcer
☐ Diabetes	☐ High Blood Pressure	☐ Hernias
☐ Depression	☐ Low Blood Pressure	☐ Ears, eyes, nose, throat
☐ Coughing Blood	☐ Kidney, Bladder (GU)	☐ Tumors
☐ Stomach, Intestines (GI)	☐ Circulatory Problems	☐ Heart Disease

SURGERIES YOU MAY HAVE HAD Date (s)

Spine Surgeries ☐ Discectomy ☐ Laminectomy ☐ Fusion ☐ Other:_____ _____

Other Surgeries _____ _____

NON-SURGICAL TREATMENTS YOU MAY HAVE RECEIVED: ***(place "X" in boxes that apply)***

☐ Medication *(OTC / Prescription)*	☐ Injections	☐ Physical Therapy *(Dates:_____)*
☐ Massage	☐ Chiropractic	☐ Acupuncture
☐ Other: _____		

Female patients: Start date of most recent menstrual cycle: _____ Are you currently pregnant? ☐ Yes ☐ No

8 YOUR DOCTORS

Please List ALL Doctors involved in your healthcare, present and past. (Use back if necessary)

Name *Phone*

Primary / Family Doctor: _____ _____

Orthopedic Doctor: _____ _____

Pain Management: _____ _____

Neurologist: _____ _____

Chiropractor: _____ _____

9 AUTHORIZATION FOR TREATMENT

I hereby authorize the Doctor to treat my condition as she deems appropriate and to furnish any authorized requests for information regarding treatment. It is understood and agreed that the amount paid to the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office. They will be kept on file where they may be seen at any time while the patient is being treated at this office. The patient also agrees that he/she is responsible for all bills incurred at this office. (The Doctor will not be held responsible for any preexisting medically diagnosed conditions, nor for any medical diagnosis). The patient also agrees that statements made in this questionnaire are true and correct.

Patient's Signature:_____ Date:_____

Guardian's Signature:_____ Date:_____