

CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION	INSURANCE INFORMATION
Date _____ Patient Name _____ Address _____ _____ City _____ State _____ Zip _____ Sex ___ M ___ F Age _____ Date of Birth _____ Marital Status _____ No. Children _____ Spouses Name _____ Home Phone _____ Work Phone _____ Cell Phone _____ Social Security Number _____-_____-_____ Occupation _____ Referred By _____ Primary Care Physician Name _____ Primary Care Physician Phone _____ -----	Who is responsible for this account? _____ Relationship to patient _____ Insurance Co. _____ Subscribers Name _____ Is Patient covered by additional insurance? ___ YES ___ NO Insurance Co. _____ ASSIGNMENT AND RELEASE I certify that I, and/or my dependents, have insurance coverage with _____ and assign directly to Knopp Chiropractic 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. _____ Signature of patient, parent, Guardian or Personal Representative _____ Please print name of Patient, Parent, Guardian or Personal Representative _____ Date _____ Relationship to Patient _____ <p style="text-align: center;">PLEASE GIVE THE FRONT DESK A COPY OF YOUR INSURANCE CARD!</p>
IN CASE OF EMERGENCY Name _____ Relationship _____ Home Phone _____ Work Phone _____ Cell Phone _____	

PATIENT CONDITION	
Reason for visit _____ When did your first symptoms appear? _____ Is this condition getting progressively worse? ___ YES ___ NO ___ UNKNOWN Mark an X on the picture where you continue to have pain, numbness or tingling. Rate the severity of your pain on a scale from 0 (no pain) to 10 (severe pain) _____ Type of Pain: ___ Sharp ___ Dull ___ Throbbing ___ Numbness ___ Aching ___ Shooting ___ Burning ___ Tingling ___ Cramps ___ Stiffness ___ Swelling ___ Other How often do you have this pain? _____ Is it constant or does it come and go? _____ Does it interfere with your ___ Work ___ Sleep ___ Daily routine ___ Recreation Activities or movements that are painful to perform: ___ Sitting ___ Standing ___ Walking ___ Bending ___ Lying Down	