CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Date_____

Social Security #_____

Patient Name_____
Last

_____
First Name Middle Initial

Address_____

City_____

State_____ Zip_____

Sex M_____ F_____ Age_____

Birthdate_____

Married_____ Single_____ Divorced_____
Separated_____ Widowed_____ Minor_____

Patient Employer_____

Address_____

Phone #_____

Occupation_____

Spouse's Name_____

Birthdate_____

Social Security # _____

Spouse's Employer_____

INSURANCE INFORMATION

Who is responsible for this account?
_____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes_____ No_____

Subscriber's Name_____

Birthdate _____ SS #
_____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Assignment and Release
I certify that I and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company

Dr. Adam Akers 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 authorize the use of my signature on all insurance submissions.

The above named doctor 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 completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient. Parent. Guardian or Personal Representative

PHONE NUMBERS

Cell Phone ( )_____ Home Phone _____

Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship _____

Home Phone ( )_____ Work Phone ( )_____

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?

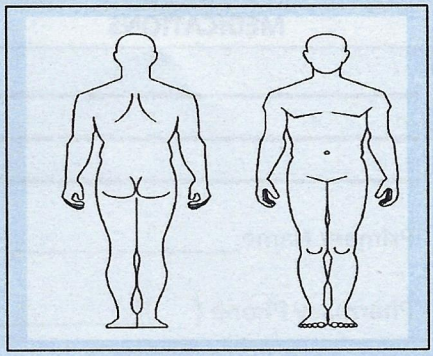
Auto Insurance____ Employer ____ Worker Comp ____ Other ____

PATIENT CONDITION

Reason for visit _____
When did symptoms appear? _____
Is condition getting 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 1 (least 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 ___



What treatment have you already received for your condition? Medications _____ Surgery _____ Physical Therapy _____ Chiropractic _____ None____

Name and address of other doctor(s) who have treated you for your condition_____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____ Spinal Exam_____

Chest Exam_____ Urine Test_____ MRI, CT Scan, Bone Scan_____

Have you had any of the following? Please Circle all that apply:

AIDS/HIV Alcoholism Allergy Shots Anemia Anorexia Appendicitis Arthritis Asthma Bleeding Disorder Breast Lump Bronchitis

Bulimia Cancer Cataracts Chemical Dependency Chicken Pox Diabetes Emphysema Epilepsy Fractures Glaucoma Goiter Gonorrhea

Gout Heart Disease Hepatitis Hernia Herniated Disk Herpes High Blood Pressure High Cholesterol Kidney Disease Liver Disease

Measles Migraine Headaches Miscarriage Mononucleosis Multiple Sclerosis Mumps Osteoporosis Pacemaker Parkinson's Disease

Pinched Nerve Pneumonia Polio Prostate Problems Prosthesis Psychiatric Care Rheumatoid Arthritis Rheumatic Fever Scarlet Fever

Sexually Transmitted Disease Stroke Suicide Attempt Thyroid Problems Tonsillitis Tuberculosis Tumor Growths Typhoid Fever Ulcers

Vaginal Infections Whooping Cough Other_____

EXERCISE	**WORK ACTIVITY**	**HABITS**	
____None	____Sitting	____Smoking	Packs/Day_____
____Moderate	____Standing	____Alcohol	Drinks/Weeks_____
____Daily	____Light Labor	____Coffee/Caffeine Drinks	Cups/Day_____
____Heavy	____Heavy Labor	____High Stress Level	Reason_____

Are you pregnant? ____Yes ____No

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS/MINERALS**
Primary Name_____		
Pharmacy Phone ( )_____		