Chiropractic Registration and History

Patient Information

Date ______________________________

Patient ____
First Middle Initial Last

Address ____

____
City State Zip

E-mail ____

Sex: ☐ M ☐ F Age_____ Birthdate____________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation ____

Patient Employer/School ________________________________

Employer/School Address ________________________________

____

Employer/School Phone __________________________________

Spouse's Name ______________________________________

Birthdate ____

Spouse's Employer ____________________________________

Whom may we thank for referring you?

____

Phone Numbers

Home (______) ________________ Cell (______) ______________

Work (______)________________ Ext__________

Best time and place to reach you ____________________________

IN CASE OF EMERGENCY, CONTACT

Name________________________ Relationship ______________

Home Phone (____) ____________ Work Phone (_____) _________

Insurance

Who is responsible for this account? __________________________

Relationship to Patient ______________________________________

Insurance Co. ____

Group# ____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name` ____

Birthdate ____

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 Dr. Gene Aiello, D.C. 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this 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

____
Date Relationship to Patient

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

Attorney Name (if applicable) ________________________________

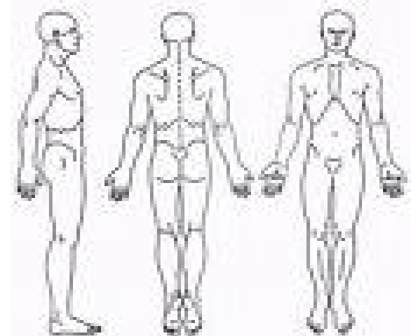
Patient Condition

Reason for visit ____

When did your 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 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 ☐ Lying Down

Health History

What treatments have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other ____________________________

Name and Address of other doctor(s) who have treated your condition ____

Date of Last

Physical Exam ______________	Spinal X-ray ______________________	Blood Test____________________________
Spinal Exam ________________	Chest X-ray _______________________	Urine Test ____________________________
Dental X-ray ________________	MRI, CT scan _____________________	Bone Scan __________________________

Please circle to indicate if you have had any of the following

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

Exercise

☐ None
☐ Moderate
☐ Daily
☐ Heavy

Work Activity

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

Habits

☐ Smoking	Packs/Day______________________
☐ Alcohol	Drinks/Week_____________________
☐ Coffee/Caffeine Drinks	Cups Day ______________________
☐ High Stress Level	Reason ________________________

Are you pregnant? ☐ No ☐ Yes Due Date _________________

Injuries and Surgeries you have had	**Description**	**Date**
Falls	____________________________________	______________________
Head Injuries	____________________________________	______________________
Broken Bones	____________________________________	______________________
Dislocations	____________________________________	______________________
Surgeries	____________________________________	______________________

Medications	Allergies	Vitamins/Herbs/Minerals
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Pharmacy Name ____

Pharmacy Phone ____