

Jenkins Chiropractic Registration & History

Patient Information

Date: ___/___/___

Patient: _____ Birthdate: ___/___/___ Age: ___ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Height: _____ Weight: _____ Marital Status: Single Married Divorced Widowed

Patient SS #: _____ Email: _____

Home Phone #: _____ Cell #: _____ Work #: _____

Occupation: _____ Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Birthdate: ___/___/___ Occupation: _____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY CONTACT:

Name: _____ Home Phone: _____ Work/Cell: _____ Relationship: _____

Insurance

Be sure to provide the receptionist with all health insurance cards and photo ID

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Jenkins 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. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the signature on all insurance

_____ / _____ / _____
Responsible Party Signature

Relationship

Date

Accident Information

Is this condition due to an accident? Yes No Type of accident: Auto Work Home Other Injury Date: _____

To whom have you made a report of your accident? Auto Insurance Employer Worker Comp Other: _____

***Are you pregnant** Yes No Due Date: _____ Comments: _____

Patient Condition

Primary reason for visit: _____

How did this occur?: _____

Symptoms appeared: Gradually Suddenly

How long have you had this pain? _____ Years / Months / Weeks / Days

Mark an X on the picture to the right where you are having pain or discomfort ---->

Type of pain: Aching Burning Diffused Dull Numbness Sharp
 Shooting Throbbing Tightness Tingling

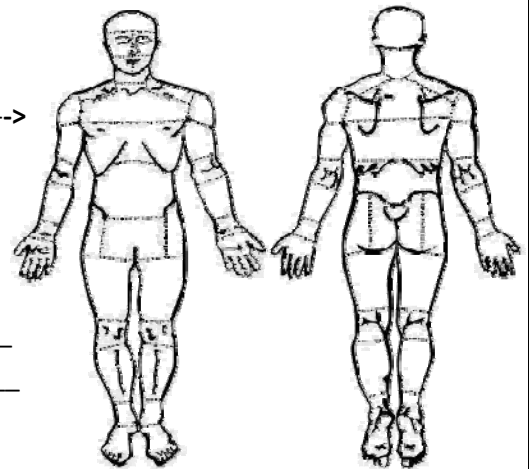
How frequently do you have this pain? (Check one below):
 Constant Frequent Intermittent Occasional

Symptoms are aggravated by: _____

Symptoms are reduced by: _____

Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10

What time of day is the pain most noticeable? _____



****Turn Over****

Patient Condition (cont.)

Second reason for visit: _____

How did this occur?: _____

Symptoms appeared: Gradually Suddenly

How long have you had this pain? _____ Years / Months / Weeks / Days

Mark an X on the picture to the right where you are having pain or discomfort ---->

Type of pain: Aching Burning Diffused Dull Numbness Sharp
 Shooting Throbbing Tightness Tingling

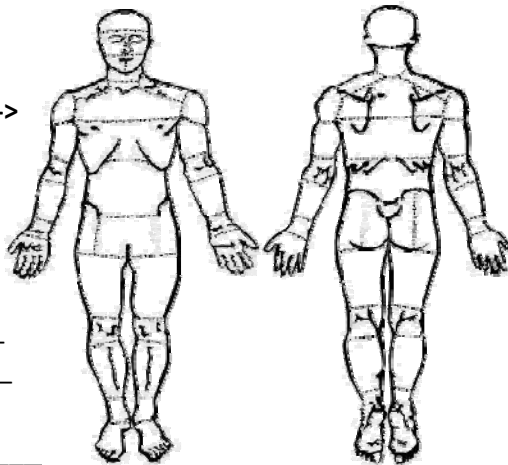
How frequently do you have this pain? (Check one below):
 Constant Frequent Intermittent Occasional

Symptoms are aggravated by: _____

Symptoms are reduced by: _____

Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10

What time of day is the pain most noticeable? _____



Third area of discomfort: _____

How did this occur?: _____

Symptoms appeared: Gradually Suddenly

How long have you had this pain? _____ Years / Months / Weeks / Days

Mark an X on the picture to the right where you are having pain or discomfort ---->

Type of pain: Aching Burning Diffused Dull Numbness Sharp
 Shooting Throbbing Tightness Tingling

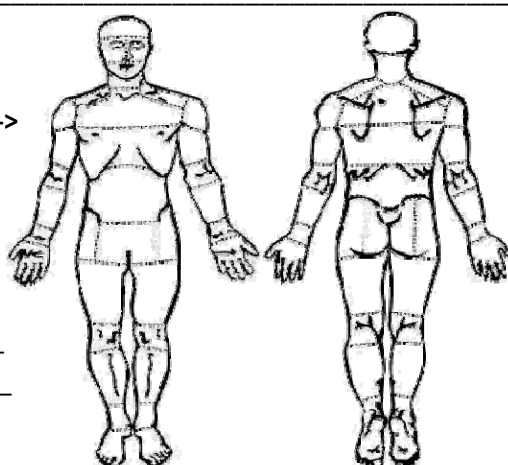
How frequently do you have this pain? (Check one below):
 Constant Frequent Intermittent Occasional

Symptoms are aggravated by: _____

Symptoms are reduced by: _____

Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10

What time of day is the pain most noticeable? _____



Health History

*Please check **all** conditions below that you currently have or have had in the past*

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Heartburn/Acid reflux	<input type="checkbox"/> Menstral irregularities	<input type="checkbox"/> Prostate problems
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Dependency	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Prosthesis
<input type="checkbox"/> Allergies	<input type="checkbox"/> Constipation	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Allergy Shots	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Ringing in the ears
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hernia	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Herniated Disc	<input type="checkbox"/> Mumps	<input type="checkbox"/> Sleeping problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Herpes	<input type="checkbox"/> Nervousness/Anxiety	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Asthma/Short of breath	<input type="checkbox"/> Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Emphysema	<input type="checkbox"/> IBS	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Tumors/Growths
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Pinched nerve	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Upset stomach
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Headaches	<input type="checkbox"/> Measles	<input type="checkbox"/> Polio	<input type="checkbox"/> Vaginal infections

Any other conditions not listed above: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working for the same goals. Chiropractic does NOT diagnose or treat disease. Chiropractic has only one goal:

To LOCATE, ANALYZE, AND CORRECT SPINAL INTERFERENCE TO THE NERVOUS SYSTEM

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain, and promote natural health.

WE DO NOT DIAGNOSE CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS

WE DO NOT OFFER TREATMENT OF CONDITION(S) OR DISEASE(S) OTHER THEN VERTEBRAL SUBLUXATIONS.

WE PROMISE NO CURE FROM ANY CONDITION(S) OR DISEASE(S)

THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO ITS FULLEST POTENTIAL!!!

I, _____, having read the above statement, and understanding it fully,
(Please Print Name)

do undertake chiropractic health care on this basis.

X _____
Signature Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

By signing below, I indicate that a copy of Jenkins Chiropractic Notice of Privacy Practices has been made available to me and understand that my signature indicates my consent to the use and disclosure of protected health information by Jenkins Chiropractic as described in that notice.

X _____
Signature Date
(Legal Guardian's Signature if Minor)