Lundstrom Chiropractic
Chiropractic Registration and History

Patient Information

Date_____

Patient Name:

_____

Address _____

City_____

State_____ Zip_____

E-mail_____

Sex ☐ M ☐ F Age _____

Birth-date_____

Marital Status_____

Occupation_____

Employed by, or

Name of School _____

Employer/School Phone _____

SS#_____

Whom may we thank for referring you?

_____

Phone Numbers

Home Phone_____

Cell Phone_____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Home Phone_____

Work Phone_____

Accident Information

Is this condition due to an accident? ☐ Yes ☐ No

If so, When did it occur? _____

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)_____

Insurance

Name of Insurance: _____

Name of Subscriber: _____

Subscriber DOB: _____

Policy # _____

Group # _____

Is patient covered by additional insurance? ☐ Y ☐ N

Name of Insurance: _____

Name of Subscriber: _____

Subscriber DOB: _____

Policy # _____

Group # _____

ASSIGNMENT AND RELEASE

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

Name of Insurance Company(ies)

directly to Lundstrom Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Lundstrom Chiropractic may use my health care information and my disclose such information to the above 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.

_____

Signature of Patient, Parent, Guardian, or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting worse? ☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐

Numbness

☐ Aching ☐ Shooting ☐ Burning ☐

Tingling

☐ Cramps ☐ Stiffness ☐ Swelling ☐

Other

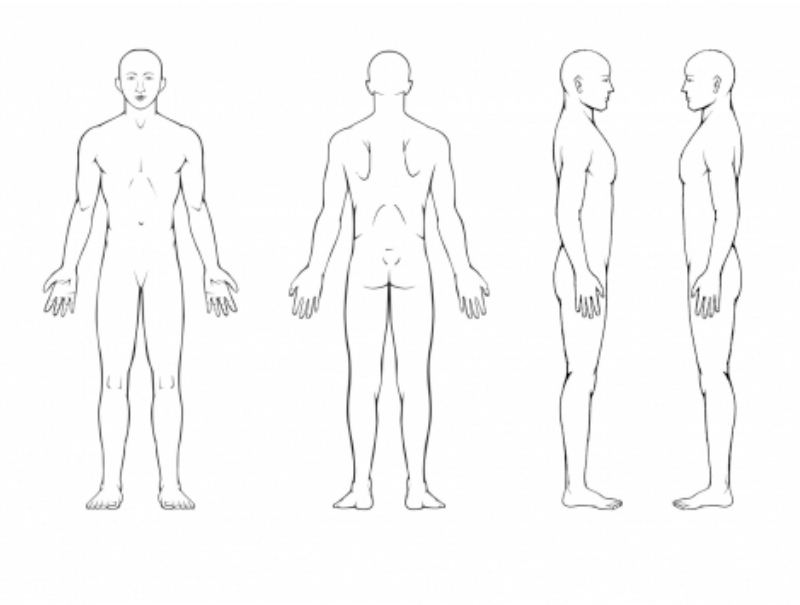
How often do you have this pain?

_____

Is it constant or does it come and go?

_____

Mark with an "X" where your symptoms are:



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 treatment have you already received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other: _____

Name of other doctor(s) who have treated you for your condition _____

_____

Date of Last: Physical Exam_____ Spinal X-ray_____Spinal Exam_____

MRI, CT-Scan, Bone Scan_____

Please **List** and **Date** any Significant Injuries or Surgeries that you have had

Falls _____ Head Injuries _____

Broken Bones _____ Dislocations_____

Surgeries _____ Other _____

Please List any Prescription and Over-the-Counter Medication you are currently taking, including reason

_____

_____

Do you have any Allergies? ☐ No ☐ Yes If so, please list _____

How often do you exercise ☐ Daily ☐ 3x's / week ☐ 2x's / week ☐ 1x / week ☐ Never

Describe your work activity ☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy labor

Do you use tobacco? ☐ Never ☐ Yes - _____ packs per day / week / month

Do you drink alcohol? ☐ Never ☐ Yes - _____ drinks per day / week / month

Do you drink coffee/soda? ☐ Never ☐ Yes - _____ drinks per day / week / month

How many hours of sleep do you get? _____ hours.

Family History

Please mark the following conditions that pertain to your immediate family.

	Father	Mother	Brother	Sister
Arthritis	☐	☐	☐	☐
Back Pain	☐	☐	☐	☐
Blood Disorders	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐
Heart Problems	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐

Review of Systems

Please mark the following conditions that are currently a significant concern for you.

- Sudden Weight Loss/Gain ☐
- Fatigue ☐
- Headaches ☐
- Dizziness ☐
- Loss of Sleep ☐
- Constipation ☐
- Stomach Pain ☐
- Poor Appetite ☐
- Poor Digestion ☐
- Frequent Colds ☐
- Chest Pain ☐
- Difficulty Breathing ☐
- Backache ☐
- Spinal Curvature ☐
- Foot Problems ☐
- Swollen Joints ☐
- Arthritis ☐
- Pain between Shoulders ☐
- Painful Tailbone ☐
- Stiff Neck ☐
- Weakness ☐
- Bruise Easily ☐
- Knee Pain ☐
- Shoulder Pain ☐
- Wrist Pain ☐
- Elbow Pain ☐
- Hip Pain ☐

Have you ever suffered from:

Cancer	☐Yes	☐No
Diabetes	☐Yes	☐No
Emphysema	☐Yes	☐No
Epilepsy	☐Yes	☐No
Gout	☐Yes	☐No
Heart Disease	☐Yes	☐No
Hernia	☐Yes	☐No
Herniated Disc	☐Yes	☐No
Kidney Disease	☐Yes	☐No
Liver Disease	☐Yes	☐No
Mental Disorders	☐Yes	☐No
Pinched Nerve	☐Yes	☐No
Prostate Problem	☐Yes	☐No
Stroke	☐Yes	☐No
Thyroid Problem	☐Yes	☐No
Ulcers	☐Yes	☐ No
Other:		

I understand and agree to the following:

- I have completed this form accurately and to the best of my knowledge.
- A history, consultation, examination, and X-rays are conducted for diagnostic and informational purposes and I am requesting these services.
- It is my responsibility to notify the doctor if any of my information has changed or requires updating.

Patient Signature: _____

Date: _____