Lundstrom Chiropractic
Registration & History

Patient Information

Date:_____

Patient Name:

_____

Mailing Address:

_____

City:_____

State:_____ Zip:_____

Email:_____

Age:_____ Sex: Male ☐ Female ☐

Date of Birth:_____

Marital Status:_____

Occupation:_____

Employer/School:_____

Whom may we thank for referring you?

_____

Phone Numbers

Home:_____

Cell:_____

IN CASE OF EMERGENCY, CONTACT:

Name:_____

Relationship:_____

Phone:_____

Accident Information

Is your condition due to an auto or work related accident?

No ☐ Yes ☐ Auto ☐ Work ☐

To whom have you make a report/claim of your accident?

Auto insurance ☐ Employer ☐

Workers comp ☐ Other ☐

Insurance

SEE CARD ☐

Name of Insurance:_____

Name of subscriber:_____

Subscriber DOB:_____

Policy #:_____

Group#:_____

Secondary coverage:_____

Name of subscriber:_____

Subscriber DOB:_____

Policy #:_____

Group #:_____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above stated insurance companies and assign 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 charges, whether of not paid by insurance. I authorize the use of my signature on all insurance submissions.

Lundstrom Chiropractic may use my health care information and may 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

_____

Print Name

_____

Date

Patient Name_____ Date:_____

Patient Condition

Reason for visit (neck pain, low back pain, etc.):_____

When did your symptoms appear?_____

Are your symptoms getting worse? Yes ☐ No ☐ Unsure ☐

Please rate the severity of your pain on a scale of 1 (very minimal) to 10 (severe/debilitating):_____

Please describe your symptoms:

Sharp	☐	Dull	☐	Stabbing	☐
Tingling	☐	Weakness	☐	Tenderness	☐
Stiffness	☐	Swelling	☐	Burning	☐

How often are you having these symptoms?_____

Are your symptoms constant, or do they come and go?_____

Do your symptoms interfere with any of the following?

Sitting	☐	Driving	☐	Lift/Carrying	☐	Sleeping	☐	Walking	☐
Chores	☐	Dressing	☐	Standing	☐	Self Care	☐	Exercise/Recreation	☐

Are your symptoms made worse by any of the following?

Twisting/Turning	☐	Bending Forward	☐	Walking	☐	Sitting	☐
Cough/Sneeze	☐	Bending Backward	☐	Lying Down	☐	Standing	☐

Please use the diagram to label the areas of your symptoms

What types of treatment have you already tried for this condition

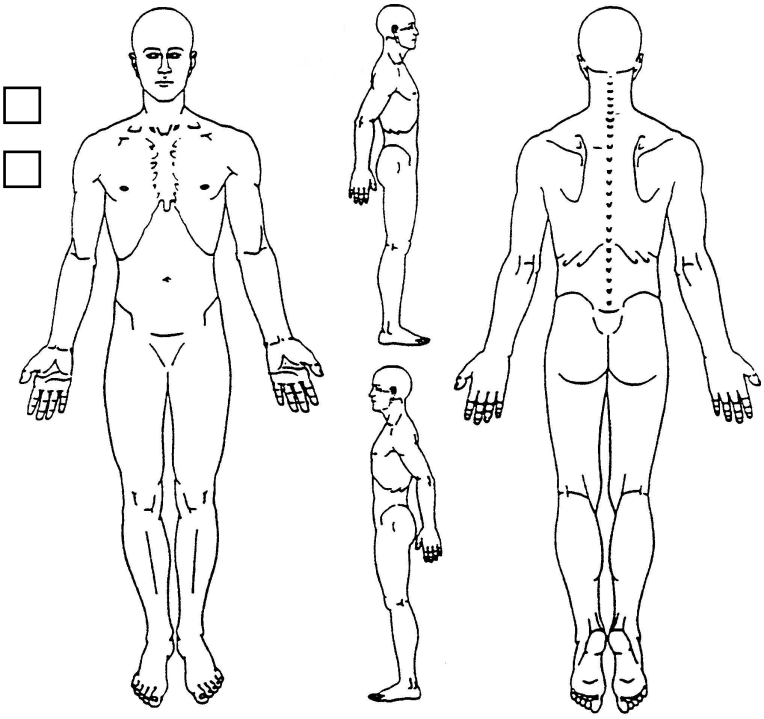
None	☐	Medication	☐	Surgery	☐
Physical Therapy	☐	Chiropractic	☐	Other	☐

Name of other Doctor(s) who have treated you for this condition:

_____

_____

_____



Patient Name_____ Date:_____

Date of Last:

Physical Exam_____ Spinal X-ray_____ Spinal Exam_____ MRI/CT scan_____

Please date any significant injuries/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:

_____

_____

How often do you exercise?_____

Describe your work activity:_____

Do you smoke? NO YES How much?_____

Do you drink alcohol? NO YES How much?_____

Do you drink caffeine? NO YES How much?_____

How many hours of sleep do you get?_____

Family History

Please mark the following conditions that pertain to your immediate family

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

Patient Name_____ Date:_____

Review of Systems

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

Sudden weight loss/gain	☐	Foot problems	☐	Painful tailbone	☐
Fatigue	☐	Swollen joints	☐	Stiff neck	☐
Headache	☐	Arthritis	☐	Weakness	☐
Dizziness	☐	Pain between shoulders	☐	Bruise easily	☐
Loss of sleep	☐	Frequent Colds	☐	Knee pain	☐
Constipation	☐	Chest pain	☐	Shoulder pain	☐
Stomach pain	☐	Difficulty breathing	☐	Wrist pain	☐
Poor appetite	☐	Backache	☐	Elbow pain	☐
Poor Digestion	☐	Spinal curvature	☐	Hip pain	☐

Please mark the following conditions that you have ever suffered from.

Cancer	☐	Gout	☐	Kidney Disease	☐	Prostate problem	☐
Diabetes	☐	Heart Disease	☐	Liver Disease	☐	Stroke	☐
Emphysema	☐	Hernia	☐	Mental Disorders	☐	Thyroid problem	☐
Epilepsy	☐	Herniated Disc	☐	Pinched Nerve	☐	Ulcers	☐

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 / informational purposes, and I am requesting these services, as well as consenting to treatment and possible risks associated with treatment performed within this office.**
- **It is my responsibility to notify the doctor if any of my information has changed or requires updating.**

Patient

Signature:_____ **Date:**_____