

# CHIROPRACTIC REGISTRATION AND HISTORY

## 1

### PATIENT INFORMATION

Date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Patient SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 2

### 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 \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

#### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ 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.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_

Date \_\_\_\_\_

## 3

### PHONE NUMBERS

Home \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

#### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## 4

### 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) \_\_\_\_\_

## 5

### 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) \_\_\_\_\_

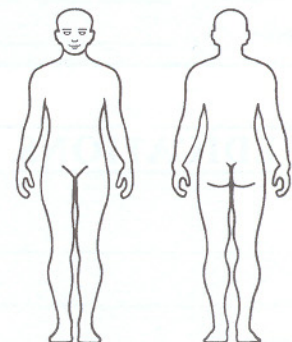
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other \_\_\_\_\_

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 \_\_\_\_\_



# 6

## HEALTH HISTORY

What treatment 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 you for 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 \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |  |   |   |   |
|--|---|---|---|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No            | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No          | Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No          | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No          | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No           | Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No        | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No       | Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No          | Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No   | Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No              | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No           | Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No                | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No            | Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No             | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No         | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No        |
| Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No        | Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No          | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No            | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No           | Gout <input type="checkbox"/> Yes <input type="checkbox"/> No               | Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No  | Tumors, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No              | Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No      | Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No        | Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No  | Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No          | Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No            | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No         | Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No             | Polio <input type="checkbox"/> Yes <input type="checkbox"/> No                | Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No          | Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No     | Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No     | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No             | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No             | Prostneis <input type="checkbox"/> Yes <input type="checkbox"/> No            | Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No              | High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No   | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No     | Other _____   |
| Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No           | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No     | Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | _____   |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No      | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No      | _____   |
| Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No         | Measles <input type="checkbox"/> Yes <input type="checkbox"/> No            |   |   |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No            | Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |

### 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?  Yes  No Due Date \_\_\_\_\_

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

# 7

## MEDICATIONS

## ALLERGIES

## VITAMINS/HERBS/MINERALS

Pharmacy Name _____ Pharmacy Phone _____		
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# Neck Index

ACN Group, Inc. - Form N1-100

Patient #: \_\_\_\_\_

ACN Group, Inc. Use Only rev 11/13/2002

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Section 1 - Pain Intensity

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

## Personal Care

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

## Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

## Driving

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

## Recreation

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all of my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

## Headaches

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

## Sleeping

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

## Reading

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

## Concentration

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty in concentrating when I want.
- ⑤ I cannot concentrate at all.

## Work

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

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Score

# Back Index

ACN Group, Inc. - Form B1-100

Patient #: \_\_\_\_\_

ACN Group, Inc. Use Only rev 11/13/2002

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

- ⓪ The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- ② The pain comes and goes and is moderate.
- ③ The pain is moderate and does not vary much.
- ④ The pain comes and goes and is very severe.
- ⑤ The pain is very severe and does not vary much.

## Sleeping

- ⓪ I have no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

## Sitting

- ⓪ I can sit in any chair as long as I like.
- ① I can only sit in my favorite chair as long as I like.
- ② Pain prevents me from sitting more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

## Standing

- ⓪ I can stand as long as I want without pain.
- ① I have some pain while standing but it does not increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- ③ I cannot stand for longer than 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

## Walking

- ⓪ I have no pain while walking.
- ① I have some pain while walking but it doesn't increase with distance.
- ② I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- ④ I cannot walk more than 1/4 mile without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

## Personal Care

- ⓪ I do not have to change my way of washing or dressing in order to avoid pain.
- ① I do not normally change my way of washing or dressing even though it causes some pain.
- ② Washing and dressing increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ④ Because of the pain I am unable to do some washing and dressing without help.
- ⑤ Because of the pain I am unable to do any washing and dressing without help.

## Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

## Traveling

- ⓪ I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

## Social Life

- ⓪ My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.)
- ③ Pain has restricted my social life and I do not go out very often.
- ④ Pain has restrictged my social life to my home.
- ⑤ I have hardly any social life because of the pain.

## Changing degree of pain

- ⓪ My pain is rapidly getting better.
- ① My pain fluctuates but overall is definitely getting better.
- ② My pain seems to be getting better but improvement is slow.
- ③ My pain is neither getting better or worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

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