PATIENT REGISTRATION FOR TREATMENT

Today's Date: ______________________________

PATIENT INFORMATION

Please Print

Patient Name____ SS#______/______/______

Street Address____City___________________________State_________Zip________

Age_______ Date of Birth________________ Sex: M F [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Minor

Occupation ________________________________ Employer ____

Employer Address ____ Email: ______________________________________

Spouse or parent name of patient if minor: ____

Referred by_____________________________________ Yellow Pages ( ) Other ( )

Home Phone# _______________________ Work# _________________________ Cell# or Contact# __________________________

IN CASE OF EMERGENCY: CONTACT

Name____ Relationship ____

Home Phone __________________________________ Work Phone ____

INSURANCE INFORMATION

Who's responsible for payment? ( ) Self – No Insurance ( ) Insurance ( ) Other__________________________________

Policyholder's Name (if other than patient) ________________________________ Relationship to Patient ____________________

Policyholder's Date if Birth _________/_________/_________ SS# _________/_________/________

Insurance Co. ___________________________________ ID#_______________________________ Group# ______________________

Is Patient covered by additional insurance? [ ] Yes [ ] No

Policyholder's Name (if other than patient) ________________________________ Relationship to Patient_________________

Policyholder's Date of Birth ________/________/________ SS# ________/________/________

Insurance Co. ___________________________________ ID# _______________________________ Group#____________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above-name Insurance Company(ies) and assign directly to Dr. James M. Vanderloop, 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 authorize the use of my signature on all insurance submissions.

The above-name 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 treatment is completed or one year from the date signed below.

____ ____________________

Signature of Patient, Parent, Guardian or Personal Representative Date

____ ____________________

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

____

Relationship to Patient

PATIENT CONDITION

Patient Name____ Date____________________________

Have you ever had Chiropractic care? [ ] Yes [ ] No How long has it been?___________________________

The purpose or reason for this appointment (chief complaint)? ____

Have you ever seen any other doctor for this problem? [ ] Yes [ ] No If yes, name of Doctor___________________________________

When did this problem first begin? ____

Is this condition getting worse? [ ] Yes [ ] No [ ] Unknown

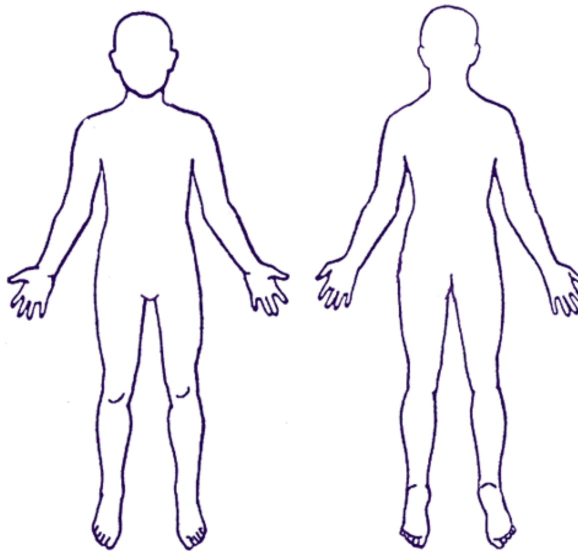
Are you currently experiencing any pain or symptoms? [ ] Yes [ ] No

Rate of severity of your pain on a scale from 1 (least pain) to 10 (severe pain): 0 1 2 3 4 5 6 7 8 9 10
NONE LITTLE MEDIUM SEVERE

Type of pain:

[ ] Aching	[ ] Muscle Spasms	[ ] Shooting	[ ] Swelling
[ ] Burning Sensation	[ ] Numbness	[ ] Stiffness	[ ] Other_________________
[ ] Cramping	[ ] Sharp	[ ] Throbbing	
[ ] Dull	[ ] Tingling	[ ] Swelling	_______________________

On the diagram below, please show *Where* you are experiencing pain or symptoms related to your complaint



How long have you been in pain? Days_______ Weeks_______ Months_______ Years_______

When do you notice it most? [ ] AM [ ] PM How long does it lasts? _________minutes __________hours

What makes it feel better? ____ Worse? _____________________________________

What treatment have you already received for your condition? [ ] Medications [ ] Surgery [ ] Physical Therapy [ ] Chiropractic [ ] None

Does it interfere with your [ ] Work [ ] Sleep [ ] Dailey Routine [ ] Recreation [ ] School

Activities or movements that are painful to perform [ ] Sitting [ ] Standing [ ] Walking [ ] Bending [ ] Lying Down

HEALTH HISTORY

Patient Name____ Date____________________________

When was your Last physical exam? ____

Have you ever suffered from or been diagnosed as having: (check the ones that apply)

General Questions

[ ] Weight Loss
[ ] Weight Gain
[ ] Change in sleep patterns
[ ] Change in activity capacity

[ ] **Neurologic and Physiatric**
[ ] Anxiety
[ ] Headaches
[ ] Depression
[ ] Meningitis
[ ] Paralysis
[ ] Seizure
[ ] Stroke
[ ] Tingling
[ ] Tremors
[ ] Memory loss
[ ] Fainting spells, dizziness
[ ] Head injuries
[ ] Blackouts or near blackouts
[ ] Change in sensation anywhere on your body
[ ] Localized weakness or numbness

Ears, Eyes, Nose, & Throat

[ ] Hay fever
[ ] Glaucoma
[ ] Polyps
[ ] Allergy
[ ] Cataracts
[ ] Goiter
[ ] Hoarseness
[ ] Eye Problems
[ ] Double vision
[ ] Gum problems
[ ] Ringing in your ears
[ ] Ear Infections
[ ] Glasses/contacts
[ ] Hearing loss
[ ] Ear discharge/pain
[ ] Frequent nose bleeds
[ ] Swollen glands
[ ] Sinus infections

Cardiovascular

[ ] Angina [ ] Chest Pain
[ ] Leg cramp [ ] Murmur
[ ] Ankle swelling
[ ] Awakening at night short of breath & getting out of bed
[ ] Cardiac catheterization
[ ] Cold hands or feet
[ ] Congenital heart defects
[ ] Dizziness when standing up
[ ] Heart attacks
[ ] Heart failure
[ ] High or low blood pressure
[ ] Irregular heart rate
[ ] Purple fingers or lips
[ ] Leg pain that resolves with rest
[ ] Heart palpations
[ ] Varicose veins

Respiratory

[ ] Pleurisy
[ ] Asthma
[ ] Breathless when lying flat
[ ] Prolonged cough
[ ] Coughing up blood
[ ] Emphysema
[ ] Shortness of breath
[ ] Tuberculosis
[ ] Pneumonia
[ ] Frequent infections
[ ] Wheezing

Skin

[ ] Abscess [ ] Dandruff [ ] Boils
[ ] Acne [ ] Rashes [ ] Hives
[ ] Psoriasis [ ] Dry skin
[ ] Jaundice
[ ] Fungal Infections
[ ] Nail problems
[ ] Moles-irregular
[ ] Moles-change/new
[ ] Excessive body odor
[ ] Excessive sweating
[ ] Oily skin
[ ] Athlete's foot

Kidneys and Urinary Tract

[ ] Blood in urine
[ ] Brown urine
[ ] Dribbling after urination
[ ] Painful urination
[ ] Excessive thirst
[ ] Involuntary urination/ incontinence
[ ] Urinating frequently(day)
[ ] Urinating frequently(night)
[ ] Urine hesitancy
[ ] Weak flow
[ ] Frequent bladder infections
[ ] Kidney disease
[ ] Kidney stone

Endocrine

[ ] Diabetes
[ ] Abnormal body hair
[ ] Changes in skin texture
[ ] Cold intolerance
[ ] Heat intolerance
[ ] History of "borderline" diabetes
[ ] Increased loss of hair
[ ] Rheumatism
[ ] Thyroid disease
[ ] Sickle cell
[ ] Hiatal Hernia

Males ONLY

[ ] Hernia
[ ] Blood ejaculation
[ ] Inability to complete intercourse
[ ] Lump on testicle
[ ] Penile Discharge
[ ] Premature ejaculation
[ ] Problems maintaining or keeping an erection
[ ] Prostate disease
[ ] Sores on penis or warts
[ ] Testicular pain
[ ] Testicular swelling
[ ] Sterility

Musculoskeletal

[ ] Anemia [ ] Arthritis
[ ] Back pain [ ] Bursitis
[ ] Gout [ ] Joint Aches
[ ]Neck Pain [ ]Tendonitis
[ ] Abnormal blood count
[ ] blood clots in lungs/legs
[ ] Bone marrow biopsy
[ ] Easy bleeding
[ ] Easy Bruising
[ ] Joint swelling
[ ] Morning stiffness
[ ] Muscle aches

Gastrointestinal

[ ] Diarrhea [ ] Gallstones
[ ] Reflux [ ] Vomiting
[ ] Ulcers [ ] Heartburn
[ ] Hepatitis [ ] Indigestion
[ ] Abdominal pain [ ] Constipation
[ ] Anal fissures [ ] Nausea
[ ] Black tarry stools [ ] Hemorrhoids
[ ] Vomiting blood
[ ] Problems swallowing
[ ] Intestinal obstruction
[ ] Liver disease
[ ] red blood after bowel movements

Females ONLY

[ ] D + C [ ] Hot flashes
[ ] Hernia [ ] Fibroids
[ ] Ovarian cysts [ ] Endometriosis
[ ] Vaginal Warts [ ] PMS
[ ] Vaginal dryness
[ ] Vaginal discharge
[ ] Abn. Bleeding between cycles
[ ] Abnormal pap smear
[ ] Bleeding after intercourse
[ ] Complications with pregnancy
[ ] Heavy bleeding during cycles
[ ] Discharge from breasts
[ ] Pelvic inflammatory disease
[ ] Postmenopausal symptoms

Patient Name ____ Date ____

Injuries/Surgeries you have had	**Description**	**Date**
Falls		
Head Injuries		
Broken bones		
Dislocations		
Surgeries		
Accidents		

EXERCISE	**WORK ACTIVITY**	**HABITS**	
[ ] None	[ ] Sitting	[ ] Smoking	Packs/Day____________________
[ ] Moderate	[ ] Standing	[ ] Alcohol	Drinks/Week__________________
[ ]Dailey	[ ] Light Labor	[ ] Coffee/Caffeine Drinks	Cups/Day_____________________
[ ] Heavy	[ ] Heavy Labor	[ ] High Stress level	Reason_______________________

Are you taking any medications? [ ] Yes [ ] No If yes, please list below:

Medication and/or Vitamins	Date Started	Date Stopped

==

ALLERGIES: Do you have any known allergies? [ ] Yes [ ] No
If yes, please describe____

==

WOMEN ONLY:I, ____ do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnant suspected or confirmed at this time.

==

I have read the above information and certify it to be true and correct to the best of my knowledge.

Patient Signature ____ Date ________________________
(If patient is a minor child, parent/guardian signature)