PATIENT REGISTRATION

Today's Date:

PATIENT INFORMATION

Name:

Name Preferred to Be Called:

Date of Birth:

Social Security #:

Mailing Address:

City, State, Zip:

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Home Phone #:

Cell Phone #:

Work Phone #: Ext:

Email Address:

Referred To Us By:

PRIMARY CARE PHYSICIAN

Primary Care Physician:

Street Address:

City, State, Zip:

Facility Name:

Phone #:

Fax #:

INSURANCE INFORMATION

Primary Insurance:

Subscriber's Name:

Subscriber's Birthday:

Policy No:

Relationship to Subscriber:
☐Self ☐Spouse ☐Dependant ☐Other

Subscriber's Employer:

Employer's Address:

City, State, Zip:

Employer's Phone #: Ext.

Secondary Insurance:

Subscriber's Name:

Subscriber's Birthday:

Policy No:

Relationship to Subscriber:
☐Self ☐Spouse ☐Dependant ☐Other

Subscriber's Employer:

Employer's Address:

City, State, Zip:

Employer's Phone #: Ext.

IN CASE OF EMERGENCY

Please Contact:

Relationship to Patient:

Home Phone #:

Alternate Phone #:

Assignment & Release *- By signing below, I authorize Chester Chiropractic Office to release medical records required by my insurance company(s) to obtain precertification or payment. I authorize my insurance company(s) to pay benefits directly to Chester Chiropractic Office and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred due to non-payment on this account. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

Patient / Guardian

Date

Donald Littlejohn, DC ~ Chester Chiropractic Office ~ 7 Academy Avenue, Chester NY 10918
Phone (845) 469-7575 ~ Fax (845) 469-9328 ~ Emergency (845) 987-2840

PATIENT HEALTH HISTORY

If you are presently troubled by a particular condition or have ever had a listed condition in the past, please check it in the Yes column. The information you provide concerning past and present conditions assist your doctor in more thoroughly understanding your state of health. This questionnaire is completely confidential and will not be released without your specific consent

Yes	No		Yes	No	
___	___	Neck Pain (723.1)	___	___	Aortic Aneurysm (441.5)
___	___	Shoulder Pain (719.41)	___	___	High Blood Pressure (401.9)
___	___	Pain in ☐ Upper Arm or ☐ Elbow (719.42)	___	___	Angina (413.9)
___	___	Hand Pain (719.44)	___	___	Heart Attack (411.0)
___	___	Wrist Pain (719.43)	___	___	Stroke (436.9)
___	___	Upper Back Pain (724.1)	___	___	Asthma (439.9)
___	___	Low Back Pain (724.2)	___	___	Cancer ☐ Past (V10) ☐ Present (199.1)
___	___	Pain in ☐ Upper Leg or ☐ Hip (719.45)	___	___	Tumor (229.9)
___	___	Pain in ☐ Lower Leg or ☐ Knee (729.5)	___	___	Prostate Problems (601.9)
___	___	Pain in ☐ Ankle or ☐ Foot (719.47)	___	___	Blood Disorder (790.6)
___	___	Jaw Pain (526.9)	___	___	Emphysema (Chronic Lung Disorders) (492.8)
___	___	Joint ☐ Swelling (719.0) / ☐ Stiffness (719.5)	___	___	Arthritis (716.9)
___	___	Fainting (780.2)	___	___	Rheumatoid Arthritis (714.0)
___	___	Visual Disturbances (728.9)	___	___	Diabetes ☐ Type I (250.01) ☐ Type II (250.00)
___	___	Convulsions (780.3)	___	___	Epilepsy (349.5)
___	___	Dizziness (780.4)	___	___	Ulcer (556.9)
___	___	Headache (784.0)	___	___	☐ Liver (573.9) / ☐ Gallbladder Problems (575.9)
___	___	Muscular Incoordination (781.3)	___	___	Kidney Stones (592.0)
___	___	Tinnitus (Ear Noises) (388.30)	___	___	Hepatitis (573.3)
___	___	Rapid Heart Beat (785.0)	___	___	Bladder Infection (595.9)
___	___	Chest Pain (786.50)	___	___	Kidney Disorders (V11.03)
___	___	Loss of Appetite (783.0)	___	___	Colitis (558.9)
___	___	Irritable Colon (564.1)	___	___	Abnormal Weight ☐ Gain (783.1) / ☐ Loss (783.2)
___	___	Excessive Thirst (783.5)	___	___	HIV (V08) /AIDS (042)
___	___	Chronic Cough (786.2)	___	___	Anorexia (307.1)
___	___	Chronic Sinusitis (473.9)	___	___	Systemic Lupus (710.0)
___	___	General Fatigue (780.7)	___	___	Other _____
___	___	Irregular Menstrual (626.4)			
___	___	Profuse Menstrual (611.72)	**Yes**	**No**	
___	___	Breast ☐ Soreness / ☐ Lumps (611.72)	___	___	Tobacco ☐ Present (305.1) ☐ Past (V15.82)
___	___	Endometriosis (617.9)	___	___	Alcohol If Yes, Frequency: _____
___	___	PMS (625.4)	___	___	☐ Drug / ☐ Alcohol Dependence (V11.3/303.99)
___	___	Loss of Bladder Control (788.30)	___	___	☐ Coffee / ☐ Tea / ☐ Caffeinated Soft Drinks
___	___	Painful Urination (788.1)			Servings per Day: _____
___	___	Frequent Urination (788.41)	___	___	Hospitalization / Surgeries: _____
___	___	Abdominal Pain (789.0)			_____
___	___	☐ Constipation / ☐ Irregular Bowel Habits (564.0)	___	___	Prior Accidents/Injuries: _____
___	___	Difficulty Swallowing (787.2)			_____
___	___	☐ Heartburn / ☐ Indigestion (787.1)	___	___	Current Medications (Rx, OTC, Vitamins):
___	___	☐ Dermatitis / ☐ Eczema / ☐ Rash (692.9)			_____
___	___	Depression (311.9)			_____

Yes	No	
___	___	Do You Have A Permanent Disability Rating?

Area of the Body Affected: _____

Date Rating Received: _____

Rating Percentage: _____

Please List Any Known Allergies: _____

_____

_____

Weight _____ lbs **Height** _____ Ft _____ In

Immediate Family Medical History

___ Cancer (V16)	___ Chronic Back Problems (V17.89)
___ Heart Problems (V17.4)	___ Chronic Headaches (V19.8)
___ Lung Problems (V17.6)	___ High Blood Pressure (V17.49)
___ Diabetes (V18.0)	___ Rheumatoid Arthritis (V17.7)
___ Epilepsy (V17.2)	___ Other Condition(s): _____
___ Lupus (V19.8)	_____

For Women

Yes	No	
___	___	Are You On Any Form Of Birth Control?
___	___	Are You Nursing?
___	___	Are You Or Could You Be Pregnant?
		If Yes, How Far Along? _____
		If No, Last Period? _____

_____ _____

Patient Signature Date

Donald Littlejohn, DC ~ Chester Chiropractic Office ~ 7 Academy Avenue, Chester NY 10918
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INTERSTATE CHOICE MANAGEMENT
PATIENT QUESTIONNAIRE:

Patients Name
Height _____ Weight _____ Sex _____ Age _____

1. Present Complaint _____
   _____

2. Date your symptoms started _____

3. Please describe your pain: sore _____ stiff _____ dull _____ sharp _____
   numb _____ tingle _____ burning _____ throbbing _____ other _____

4. Was the onset sudden _____ or gradual _____?

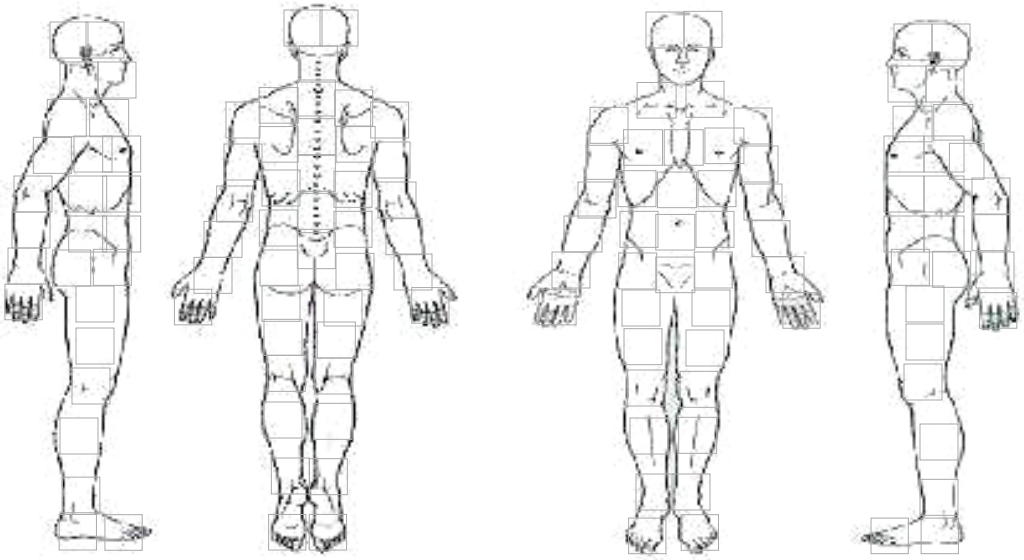
5. Has your condition gotten worse _____ better _____ or stayed the same _____
   since the onset?

6. Is your pain constant _____ frequent _____ occasional _____ or does it come and
   go_____?

7. What seems to make the pain better, rest _____ activity _____ heat _____
   ice _____ other _____?

8. What seems to make the pain worse, rest _____ activity _____ heat _____
   ice _____ other _____?

9. Please place an "X" on the pictures below where you feel the pain:



10. Have you ever been treated for the same or similar condition: yes _____ no_____?

Patients signature _____