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
Phone (845) 469-7575 ~ Fax (845) 469-9328 ~ Emergency (845) 987-2840

Chiropractic Patient Information Form Form 1B

Landmark Healthcare, Inc., 1750 Howe Ave., Suite 300, Sacramento, CA 95825

Practitioner Last Name	First Name	M.I.	License #	Phone #	Fax #
Donald	Littlejohn		X004365	845-469-7575	845-469-9328

Patient to complete the following sections:

Patient Last Name	Patient First Name	M.I.	Gender ☐M ☐F	Age	Date of Birth (MM/DD/YYYY) / /
Insured I.D. or SSN	Insured Last Name	M.I.	First Name		Patient Daytime Phone
Patient Address	City		State		Zip
Employer Name	Insurance Company		Group Plan # or Union Local		
Is illness or injury related to: ☐Work ☐Auto ☐Other	Do you have other insurance that might cover this injury/illness? ☐Yes ☐No	If yes, please list other insurance company name:			

Please list your reason(s) for this visit or your condition(s) in order of importance:	Date you first noticed:	Using a scale in which "0" is none (no pain or symptoms) and "10" is severe pain or symptom(s), **circle** the number that best reflects your condition: ↓ **none . . . . . to . . . . . severe** ↓	Please check the box below that best represents how much of the time you feel pain or your symptom(s) for the listed reason:
1 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%
2 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%
3 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%
4 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%

For each of the reasons or conditions listed above, please mark how it happened:

1. ☐Developed over time ☐Illness ☐Injury ☐Auto accident ☐Other _____ ☐ I don't know

2. ☐Developed over time ☐Illness ☐Injury ☐Auto accident ☐Other _____ ☐ I don't know

3. ☐Developed over time ☐Illness ☐Injury ☐Auto accident ☐Other _____ ☐ I don't know

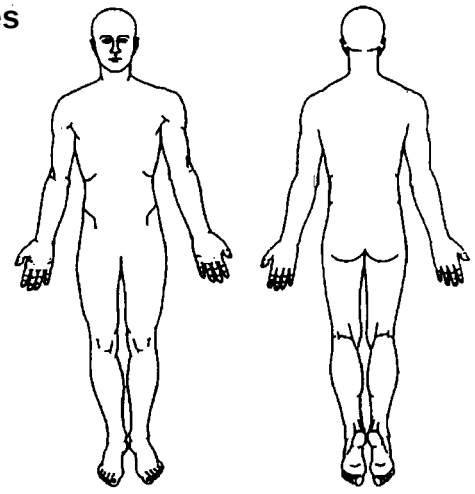
4. ☐Developed over time ☐Illness ☐Injury ☐Auto accident ☐Other _____ ☐ I don't know

For each reason listed above, please check if it is better or worse with any of the following:

	HEAT		COLD		REST		ACTIVITY		OTHER (please describe on line below)	
	better	worse	better	worse	better	worse	better	worse	better	worse
Reason 1	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
Reason 2	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
Reason 3	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
Reason 4	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____

Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:

+++ Sharp or stabbing
ooo Pins and needles
vvv Dull or aching
/ / / Numbness



Please check the box that best describes whether your pain or symptom(s) limit normal activities:

Activity	Normal	Somewhat limited	Severely limited
Lifting	☐	☐	☐
Bending	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Sitting	☐	☐	☐
Climbing stairs	☐	☐	☐
Running	☐	☐	☐
Resting in bed	☐	☐	☐
Intercourse	☐	☐	☐
Computer work/typing	☐	☐	☐
Normal work	☐	☐	☐
Household activities	☐	☐	☐
Recreational activities	☐	☐	☐
Other (list below)	☐	☐	☐

_____

-Please Continue on Page 2-

Chiropractic Patient Information Form Form 1B

Please continue …

a. During what time of the day do you feel worse? _____

b. Do you sleep well? ❑ Yes ❑No What are your normal sleeping hours? _____to _____

c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?
❑ No ❑ Yes → For what condition? _____

Name of doctor/provider _____ Phone number _____

d. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?
❑ No ❑ Yes If yes, please describe each event below:

Event _____ Year _____

Event _____ Year _____

e. Do you exercise? ❑ Yes ❑ No If yes, please describe activity _____

How many days a week? _____ How many minutes per session?_____

Personal history

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

Pain in body

- ❑ Neck pain with difficulty swallowing
- ❑ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
- ❑ Leg pain that worsens with exercise but is relieved by resting
- ❑ Loss of feeling in inner thighs
- ❑ Back pain with urinary problems

Types of pain

- ❑ Severe pain interrupts sleep
- ❑ Constant pain that doesn't improve by changing positions or lying down

Current conditions

- ❑ Unable to balance when walking
- ❑ Recent unexplained weight loss
- ❑ Recent progressive muscle weakness or shaking
- ❑ Recent or current fever over 102°F
- ❑ Loss of bowel or bladder control
- ❑ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ❑ Recent major accident such as a fall from height, whiplash or blow to the head
- ❑ Memory loss after injury

Previously diagnosed condition/ medical history

- ❑ Congenital bone or joint disorder
- ❑ Rheumatoid arthritis
- ❑ Severe degenerative arthritis
- ❑ History of compression fracture
- ❑ History of heart attack
- ❑ History of stroke or aneurysm
- ❑ Past history of cancer or currently diagnosed with cancer
- ❑ Diabetes with cold, burning or numb feet
- ❑ Gout
- ❑ Lupus
- ❑ Ankylosing spondylitis
- ❑ Immune suppression such as from chemotherapy, organ transplant, etc.
- ❑ 3 or more months use of steroid medications or intravenous drugs (past or recent)

Family history

❑ Autoimmune disorders ❑ Arthritis ❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Kidney disease ❑ Mental illness ❑ Seizure disorder

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature _____ Today's date:_____/_____/_____

If patient required assistance to complete, sign name and state relationship (i.e., parent, translator) below:

Name _____ Relationship _____ Today's date:_____/_____/_____