# Plainfield Spine And Rehab
## Registration Form
PLEASE PRINT ALL INFORMATION CLEARLY

Patient's Legal Name: ______________________________ DOB: ________________ Age: _____

Address: ______________________________ Home phone: ____________

City/State/Zip: ______________________________ Cell phone: ____________

E-mail address: ____________________________ SSN: ______________ (required for claims)

☐ I authorize your office to contact me via e-mail and cell phone

Marital status: Single Married Divorced Widow/widower Separated

If married, spouse's name: ______________________ # of children: ________

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Occupation: ____________________________ Work phone: ____________

Employer name: ________________________ Ethnicity/Race: ____________

**PERSON WHO CARRIES THE INSURANCE FOR THE PATIENT**

☐ Same as patient

Name: ______________________________ Date of birth: ________________

☐ Address same as patient

____________________________________ Home phone: ________________

____________________________________ Work phone: ________________

Relationship to patient: ___________________ Cell phone: ________________

**PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT**

☐ Same as patient

Name: ______________________________ Home phone: ________________

☐ Address same as patient Work phone: ________________

____________________________________ Cell phone: ________________

____________________________________

Relationship to patient: ___________________

# Plainfield Spine And Rehab
# Registration Form

PLEASE PRINT ALL INFORMATION CLEARLY

## NEAREST FRIEND/RELATIVE NOT LIVING WITH YOU

Name: ______________________________ Home phone: ____________________

Work phone: ____________________ Cell phone: ____________________

## EMERGENCY CONTACT INFORMATION

Name: ______________________________ Home phone: ____________________

Relationship to patient: ____________________ Work phone: ____________________

Cell phone: ____________________

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Primary Care Physician: ______________________________

How did you hear about our office? ______________________________

Relationship to patient: ______________________________

Have you ever received professional chiropractic treatments before? Yes No

If yes, have you been treated by another chiropractor during your current insurance benefit period? Yes No

## PERMISSION AGREEMENT

I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my treatment.

I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for non-covered services.

I hereby give permission to the doctor to administer treatment and perform such general procedures as deemed necessary in the diagnosis and/or treatment of my condition.

Signature: ______________________________ Date: ________________

***Plainfield Spine and Rehab***

Health Status

**Patient name:** ________________________________ **Date:** _____________

**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Low back pain

☐ Other: ________________________

**Is this?** ☐ Work related ☐ Auto related ☐ N/A

**Date problem began:** ______________

**How problem began:** ______________________________________________________________

**How would you describe your pain?** (ie: achy, burning, sharp)____________________________________

**What makes your pain worse?**__________________________________________________________

**What makes your pain feel better?**______________________________________________________

**How often are your symptoms present?** **Daily** **Weekly** **Monthly** **Yearly**

(Occasional) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% (Constant)

**In the past week, how much has your pain when its at its worse interfered with your daily activities (e.g. work, social activities, etc.)?**

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

**In the past week, how intense has your pain been at its worse on a scale of 1-10 (10 being the worst and 1 being minimal)?**

Normal 0 1 2 3 4 5 6 7 8 9 10 Unbearable

**Have you missed work or school due to your pain?**

☐ Yes ☐ No

**In general, how would you describe your overall health right now?**

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

**Have seen another physician(s) for this condition? (*If so please list names and dates*)**

______________________________________________________________________

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered, and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

**Patient signature:** ______________________________________ **Date:** ___________

## *Patient Health History*

Name: ____________________________________________________ Date: _____________

DOB: _______________ Height: ____________ Weight: ____________ M or F

**Please indicate if you have or have had any of the following conditions. This is a confidential health report.**

- ☐ Neck pain/stiffness
- ☐ Back pain/stiffness
- ☐ Arm/elbow/hand pain
- ☐ Hip/knee/leg pain
- ☐ Ankle/foot pain
- ☐ Headaches
- ☐ Arthritis
- ☐ Dizziness
- ☐ Asthma
- ☐ Tingling in arms
- ☐ Tingling in legs
- ☐ Sciatica
- ☐ Joint swelling
- ☐ Fatigue
- ☐ Sleeping difficulties
- ☐ Allergies
- ☐ Blurred vision
- ☐ Depression
- ☐ Nervousness
- ☐ Tension
- ☐ Cold sweats
- ☐ Night pain
- ☐ Sudden weight loss
- ☐ Jaw/TMJ problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Acid Reflux
- ☐ Nausea
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Wheezing
- ☐ Gallbladder problems
- ☐ Liver problems
- ☐ Kidney infections
- ☐ Kidney stones
- ☐ Fever
- ☐ Fainting
- ☐ Sinus infections
- ☐ Bowel/bladder changes
- ☐ Hemorrhoids
- ☐ Arteriosclerosis
- ☐ Heart disease
- ☐ Hypertension
- ☐ Hypotension
- ☐ Swelling of ankles
- ☐ Thyroid problems
- ☐ Goiter
- ☐ Eczema
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Autoimmune Disease
- ☐ Loss of Appetite
- ☐ Bleeding disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Hernia
- ☐ Herniated disc
- ☐ Measles
- ☐ Mumps
- ☐ Malaria
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Prosthesis/Crutch
- ☐ Rheumatoid arthritis
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease/STD
- ☐ Whooping cough

**Women only:**

- ☐ Menstrual cramps
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Lumps in breast
- ☐ Menopausal symptoms
- ☐ Painful menstruation
- ☐ Vaginal discharge/infection
- ☐ Miscarriages
- ☐ Pregnant
- ☐ Date of last period: _______

**Family History: (Please indicate any conditions in family)**

- ☐ Inflammatory Arthritis (Rheumatoid, Psoriatic)
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Neurologic Disorders (Parkinson's, Multiple Sclerosis, Lou Gehrig's, etc.)
- ☐ Autoimmune Diseases (Lupus, Scleroderma, etc.)

Other: ______________________________________________________________________

## *Patient Health History*

Name: ________________________________________________ Date: ____________

Date of last physical examination (within the last year): ____________________

Date of last blood work (within the last year): ____________________

List any medications you are currently taking:

________________________________________________________________________

________________________________________________________________________

List any vitamins/supplements/herbs you are currently taking:

________________________________________________________________________

________________________________________________________________________

List any surgeries/hospitalizations you have had:

________________________________________________________________________

________________________________________________________________________

List any known allergies:

________________________________________________________________________

________________________________________________________________________

List any broken bones/fractures you have had:

________________________________________________________________________

________________________________________________________________________

Do your work activities mostly involve:

__ Sitting __ Standing __ Light labor __ Heavy labor

What is your daily/weekly intake of the following:

Coffee: ____cups/day Soft drinks: ____cups/day Alcohol: __drinks/week

Cigarettes: ____packs/day Smokeless tobacco: ____ x/day

What is the intensity of your exercise? ___Heavy ___Moderate ___Light ___None

After reading and filling out the health history, your signature will verify that all the information you have given us is accurate and you have read all the history questions.

Signature: ________________________________________ Date: _________________