Cruz Chiropractic

Chiropractic Registration and History

1. Patient Information

Date: _____

Name: _____

Birthdate: _____

SS/HIC/Patient ID #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

E-Mail: _____

Sex: M F (Circle)

Minor Single Married Divorced

Separated Partnered for _____ years

Employer/School: _____

Occupation: _____

Employer/School Address: _____

City: _____ State: _____ Zip: _____

Employer/School Phone: _____

Spouse's Name: _____

Birthdate: _____ SS #: _____

Spouse's Employer: _____

Best time to reach you?: _____

In Case of Emergency, Contact

Name: _____ Relationship: _____

Phone: _____ Cell: _____

Whom may we thank for referering you?:

_____

2. Insurance Information

Insurance Company: _____

Group #: _____

Who is responsible for this account?:

_____

Relationship to Patient: _____

Is patient covered by additional insurance?:

Yes No

Subscriber's Name: _____

Birthdate: _____ SS #: _____

Relationship to Patient: _____

Insurance Company: _____

Group #: _____

3. Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with

_____

Name of Insurance Company(ies)

and assign directly to Dr. Brandant Cruz 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-named 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 current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please Print Name of Patient, Parent, Guardian or Personal Representative

Date: _____

Relationship to Patient: _____

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 Company Other _____

Attorney Name (if applicable): _____

5. Patient Information

Reason of Visit: _____

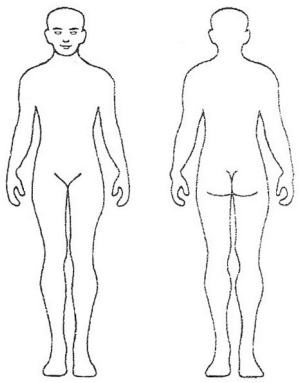
When did your symptoms appear?:

_____

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 Throbbin

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

Situation or movement 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 _____

Circle to indicate if you have had any of the following:

AIDS/HIV Alcoholism Appendicitis

Allergy Shots Anemia Anorexia

Arthritis Asthma Bleeding Disorders

Breast Lump Bronchitis Bulimia

Cancer Catarats

Chemical Dependency Chicken Pox

Diabetes Emphysema Epilepsy

Fractures Glaucoma Goiter

Gonorrhea Gout Heart Disease

Hepatitis Hernia Herniated Dis

Herpes High Blood Pressure

High Cholesterol Kidney Desease

Liver Desease Measles

Migraine Headache Miscarriage

Mononucleosis Multiple Sclerosis

Mumps Osteoporosis Pacemaker

Parkinson's Disease Pinched Nerve

Pneumonia Polio Prostate Problem

Prosthesis Psychiatric Care

Rheumatoid Arthritis Rheumatic Fever

Scarlet Fever Sexually Trans. D.

Stroke Suicide Attempt

Thyroid Problems Tonsillitis

Tuberculosis Tumors, Growths

Typhoid Fever Ulcers Vaginal Infections

Whooping Cough

Other _____

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 _____

Medications:

_____

_____

Pharmacy Name: _____

Pharmacy Phone: _____

Allergies:

_____

_____

Vitamins/Herbs/Minerals:

_____

_____

7. Family History

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climates.

CONDITION	FATHER Age:	MOTHER Age:	SPOUSE Age:	BROTHER(S) Age(s):	SISTER(S) Age(s):	CHILDREN Age(s):
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other						

If any of the above family members are deceased, please list their age at death and cause:

_____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient: _____

Signature of Patient/Legal Guardian: _____

Date: _____

8. Consultation Questionnaire

1. What is your major symptom?: _____

2. What does this prevent you from doing or enjoying?: _____

3. If this is a recurrence, when was the first you noticed this problem?: _____

   How did it originally occur?: _____

   Has it become worse recently?: Yes ___ No ___Same _____ Better _____Gradually Worse _____

   If yes, when and how?: _____

4. How frequent is the condition?: Constant _____Daily _____ Intermittent _____ Night Only _____

   How long does it last?: All Day _____ Few Hours _____ Minutes _____

5. Are there any other conditions or symptoms that may be related to your major symptom?:

   Yes _____ No _____ If yes, describe: _____

   _____

6. Describe the pain: Sharp _____ Dull _____ Numbness _____ Tingling _____ Aching _____

   Burning _____ Stabbing _____ Other _____

7. Is there anything you can do to relieve the problem?: Yes _____ No _____ If yes, describe: _____

   _____

   If no, what have you tried to do that has not helped?: _____

   _____

8. What makes the problem worse?: Standing _____Sitting _____ Lying _____ Bending _____

   Lifting _____ Twisting _____ Other _____

9. List any major accidents you have had other than those that might be mentioned above:

   _____

10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

    Yes _____ No _____ Uncertain _____

11. Remarks:

    _____

Place an "X" on the line below to indicate level of problem:

No Symptoms _____ Extreme Symptoms

Doctor's Signature: _____ Date: _____

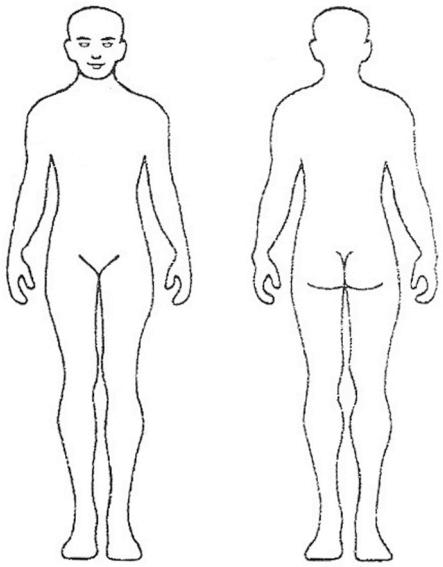
9. Subjective Pain Assessment.

Rate your pain.

Place an "X" on the drawings wherever you have pain. Beside the "X" indicate the type of pain you are experiencing.

A = Ache, B = Burning, ST = Stabbing, SP = Spasm, N = Numbness, P = Pins and Neddles, T = Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)



Pain Scale.

Please circle the number that best describes your overall pain:

0	1	2	3	4	5	6	7	8	9	10	10+
None		Little			Medium			Severe			Unbearable

Patient or Authorized Representative Signature: _____ Date: _____