RELIEF CARE CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

DATE: _____
NAME:_____
ADDRESS:_____
_____
SEX: ☐M ☐F AGE: _____ DOB_____
☐SINGLE ☐MARRIED ☐WIDOWED ☐OTHER
PATIENT SS#: _____-____-_____

OCCUPATION: _____
EMPLOYER: _____
EMPLOYER ADDRESS: _____
_____

SPOUSE'S NAME: _____
DOB: _____
SPOUSE'S EMPLOYER: _____

WHOM MAY WE THANK FOR REFERRING YOU?
_____

EMAIL: _____

INSURANCE

NAME ON ACCOUNT: _____
RELATIONSHIP TO PATIENT: _____
INSURANCE COMPANY: _____
ID #: _____
SECONDARY INSURANCE: ☐ YES ☐ NO
SUBSCRIBERS NAME: _____
DOB: _____ SS#: _____-_____-_____
RELATIONSHIP TO PATIENT_____
INSURANCE COMPANY: _____
GROUP #: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Venturi and Relief Care 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

×_____
RELATIOSHIP: _____DATE: _____

PHONE NUMBERS

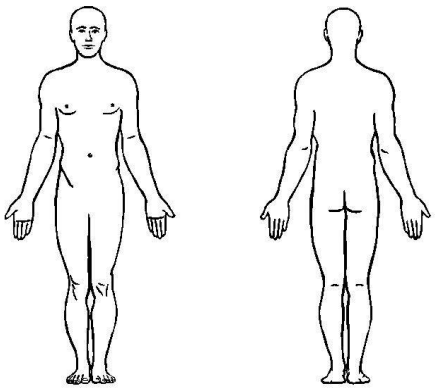
HOME: _____WORK: _____
CELL: _____
BEST TIME TO REACH YOU: _____
IN CASE OF EMERGENCY, CONTACT
NAME: _____
RELATIONSHIP:_____
PHONE #: _____

ACCIDENT INFORMATION

IS CONDITION DUE TO AN ACCIDENT:☐YES☐NO
TYPE OF ACCIDENT: ☐ AUTO ☐ WORK ☐ HOME
☐ OTHER **DOI:** _____
TO WHOM HAVE YOU MADE A REPORT:
☐AUTO INSURANCE ☐EMPLOYER ☐WORKERS COMP ☐OTHER
ATTORNEY NAME:_____

PATIENT CONDITION

REASON FOR VISIT: (WHAT IS BOTHERING YOU) _____
WHEN DID SYMPTOMS START: _____
IS CONDITION GETTING WORSE: ☐ YES ☐ NO
RATE PAIN ON A SCALE OF 0 (NO PAIN) OR 10 (SEVERE PAIN): RIGHT NOW _____ WORST _____BEST:_____
TYPE OF PAIN: ☐SHARP ☐DULL ☐THROBBING ☐NUMBNESS ☐TINGLING
☐ACHING ☐SHOOTING ☐BURNING ☐CRAMPING ☐STIFFNESS
☐SWELLING ☐STABBING ☐OTHER _____



PATIENT CONDITION

HOW OFTEN DO YOU HAVE THE PAIN: ☐CONSTANT ☐COMES AND GOES ☐OTHER_____

WHAT DOES IT INTERFERE WITH: ☐WORK ☐SLEEP ☐DAILY ROUTINE ☐RECREATION

ACTIVITIES THAT INCREASE PAIN: ☐SITTING ☐STANDING ☐WALKING ☐BENDING ☐LYING DOWN ☐LIFTING ☐STRAINING ☐COUGHING ☐STAIR STEPPING ☐STRESS ☐LIGHTS ☐STRESS ☐OTHER

WHAT MAKES THE PAIN BETTER: ☐REST ☐OTC MEDICATION ☐RXN MEDICATION ☐ICE ☐HEAT ☐NOTHING ☐OTHER_____

HEALTH HISTORY

WHAT OTHER TREATMENT HAVE YOU RECEIVED FOR YOUR CONDITION: ☐MEDICATIONS ☐SURGERY ☐PT ☐CHIROPRACTIC SERVICES ☐NONE ☐OTHER_____

NAME AND PHONE NUMBER OF OTHER DOCTOR(S) WHO HAVE TREATED YOU FOR YOUR CONDITION:

_____

DATE OF LAST EXAM: ☐PHYSICAL EXAM ☐X-RAY ☐MRI/CT ☐BLOOD TEST

PLEASE CHECK THE BOX IF YOU HAVE HAD OR HAVE ANY OF THE FOLLOWING:

☐AIDS/HIV
☐ALCOHOLISM
☐ALLERGY SHOTS
☐ANEMIA
☐ANOREXIA/BULIMIA
☐APPENDICITIS
☐ARTHRITIS
☐ASTHMA
☐BLEEDING DISORDERS
☐BREAST LUMP
☐BRONCHITIS
☐CANCER
☐CATARACTS
☐CHEMICAL DEPENDENCY
☐CHICKEN POX
☐DIABETES
☐EMPHYSEMA
☐EPILEPSY
☐GLAUCOMA
☐GOITER
☐GONORRHEA
☐GOUT
☐HEART DISEASE
☐HEPATITIS
☐HERNIATED DISC
☐HERPES
☐HIGH CHOLESTEROL
☐KIDNEY DISEASE
☐LIVER DISEASE
☐MEASLES
☐MIGRAINE
☐MONONUCLEOSIS
☐MULTIPLE SCLEROSIS
☐MUMPS
☐OSTEOPOROSIS
☐PACEMAKER
☐PARKINSON'S DISEASE
☐PINCHED NERVE
☐PNEMONIA
☐POLIO
☐PROSTATE PROBLEM
☐PROTHESIS
☐PSYCHIATRIC CARE
☐RHEUMATOID ARTHIRITIS
☐RHEUMATIC FEVER
☐STROKE
☐SUICIDE ATTEMPT
☐THYROID PROBLEMS
☐TONSILLITIS
☐TUBERCULLOSIS
☐TUMORS/GROWTHS
☐TYPHOID FEVER
☐ULCERS
☐VAGINAL INFECTIONS
☐VENEREAL DISEASE
☐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 CUPS/DAY_____
☐ HIGH STRESS LEVEL REASON _____

ARE YOU PREGNANT: ☐ YES ☐ NO **DUE DATE:** _____

IS THERE ANYOTHER INPORTANT INFORMATION YOU FEEL THE DOCTOR SHOULD KNOW: _____

_____

INJURIES/SURGERIES/HOSPITALIZATIONS

	DESCRIPTION	DATE
FALLS:	_____	_____
HEAD INJURIES:	_____	_____
BROKEN BONES:	_____	_____
DISLOCATIONS:	_____	_____
SURGERIES:	_____	_____

DO YOU HAVE ANY METAL IN YOUR SPINE: ☐ YES ☐ NO **WHERE:**_____

MEDICATIONS/VITAMINS

_____

_____

_____

_____

_____

_____

ALLERGIES

_____

PATIENT INFORMED CONSENT

I, _____, the undersigned patient, consent to treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand the consent to the clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinis staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform the clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

PATIENT SIGNATURE:_____**DATE:**_____

Relief Care Chiropractic