

Health First Chiropractic Clinic, P.C. *Patient Registration and History*

Patient Information (please print or circle information as needed) Today's Date: _____

Name: _____ Home/Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: M F Age: _____ B-date: _____ Marital Status: Single Married Divorced Widowed

Patient Soc Sec #: _____ Email: _____

Occupation: _____ Employer: _____ Work Phone: _____

*Spouse's Name (or parent's name – for children under 18): _____

*Spouse's B-date (or parent): _____ *Spouse's Soc Sec # (or parent): _____
(*required if spouse/parent is primary insured)

Whom may we thank for referring you? _____

In case of emergency whom may we contact? Name: _____

Relationship: _____ Home Phone: _____ Work Phone: _____

Is condition due to an injury? Yes No If yes type of injury? Auto Work Home Other

Primary Insurance

Subscriber's name: _____ Relationship to patient: _____ B-date: _____

Insurance Co: _____ Subscriber #: _____ Group #: _____

Secondary Insurance

Subscriber's name: _____ Relationship to patient: _____ B-date: _____

Insurance Co: _____ Subscriber #: _____ Group #: _____

Signature on file

I authorize use of this form on all my insurance submissions. I authorize release of information to all my Insurance Companies. (You are responsible for knowing your insurance coverage as we will provide the most appropriate care deemed necessary without consideration or knowledge of your insurance plan. We will submit a claim to your insurance company as a courtesy to you however, if your insurance company does not cover services rendered you will be responsible for payment.) I understand that I am responsible for my bill. I authorize Dr. Szagesh to act as my agent in helping me obtain payment from my Insurance Companies. I authorize payment direct to Health First Chiropractic Clinic, P.C. I permit a copy of this authorization to be used in place of the original.

I acknowledge that Dr. Szagesh of Health First Chiropractic Clinic, P.C. may /will be adjusting me and discussing my conditions and treatment regimen in a joint adjusting area. If I have any questions, wish to be adjusted, or to discuss my health care in private I have the option to schedule a time with the doctor in a private consultation/adjusting room.

Printed Name: _____ Signature: _____

Place an X in front of all of the following signs and symptoms that you have on a recurring basis. A complete history and understanding of your health status will facilitate care.

GENERAL SYMPTOMS

- headache
- fever
- chills
- night sweats
- fainting
- dizziness
- convulsions
- loss of sleep
- fatigue
- nervousness
- loss of weight
- numbness or pain in arms/legs/hands/feet
- allergies _____
- wheezing

MUSCLE & JOINTS

- weakness
- twitching (spasm)
- stiff neck
- back ache
- swollen joints
- tremors
- foot trouble
- painful tail bone
- pain between shoulders
- hernia

GASTRO-INTESTINAL

- poor appetite
- poor digestion
- excessive hunger
- belching or gas
- nausea
- vomiting
- vomiting blood
- pain over stomach
- constipation
- diarrhea
- colon trouble
- hemorrhoids
- liver trouble
- jaundice
- gall bladder trouble

CARDIOVASCULAR

- rapid heart beat
- slow heart beat
- high blood pressure
- low blood pressure
- pain over heart
- previous heart trouble
- swelling of ankles / edema
- poor circulation
- varicose veins
- history of stroke(s)

EYE EAR NOSE THROAT

- poor vision
- crossed eyes
- pain in eyes
- deafness
- earache
- ear noises
- ear discharges
- nasal obstruction
- nose bleeds
- sore throat
- hoarseness
- hay fever
- asthma
- frequent colds
- enlarged thyroid
- tonsillitis
- sinus trouble

SKIN

- acne
- itching
- bruising easily
- dryness
- boils
- sensitive skin
- hives
- eczema

RESPIRATORY

- chronic cough
 - spitting blood
 - spitting phlegm
 - chest pain
 - difficulty breathing
- GENITO-URINARY**
- frequent urination
 - painful urination
 - blood in urine
 - kidney infection
 - bed wetting
 - inability to control urine
 - prostate trouble (men)

FOR WOMEN ONLY

- painful periods
- excessive flow
- irregular cycles
- hot flashes
- cramps / back ache
- miscarriage
- vaginal discharge
- pregnant at this time
- if so due date: _____

HAVE YOU HAD OR HAVE ANY OF THE FOLLOWING? PLACE AN X IF YES, LEAVE BLANK FOR NO.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> appendicitis | <input type="checkbox"/> anemia | <input type="checkbox"/> heart disease | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> cancer _____ | <input type="checkbox"/> HIV/aids | <input type="checkbox"/> alcoholism |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> mumps | <input type="checkbox"/> measles | <input type="checkbox"/> polio |
| <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> epilepsy | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> vaccinations | <input type="checkbox"/> tonsillectomy | <input type="checkbox"/> tubes in ears | <input type="checkbox"/> sinus surgery |
| <input type="checkbox"/> gall bladder | <input type="checkbox"/> appendectomy | <input type="checkbox"/> female surgery _____ | <input type="checkbox"/> hernia |
| <input type="checkbox"/> rectal surgery | <input type="checkbox"/> thyroid | <input type="checkbox"/> back operations _____ | <input type="checkbox"/> stomach/ulcer |

EXERCISE

- none
- moderate
- daily
- heavy

WORK ACTIVITY

- sitting hrs/day _____
- standing hrs/day _____
- light labor
- heavy labor

HABITS

- smoking
- alcohol
- caffeine
- high stress

FAMILY HISTORY

- | | | | | |
|----------|-------|-------|--------|-------|
| | DIAB | HEART | CANCER | BACK |
| mother | _____ | _____ | _____ | _____ |
| father | _____ | _____ | _____ | _____ |
| siblings | _____ | _____ | _____ | _____ |

LIST ANY ACCIDENTS OR FALLS: Vehicle: _____

Sports: _____ School: _____

BROKEN BONES OR DISLOCATIONS (FRACTURES): _____

EVER ON CRUTCHES? YES NO IF YES, WHY? _____

HAVE YOU EVER HAD ANY SPINAL TAPS OR INJECTIONS? YES NO IF YES, WHY? _____

WERE YOU EVER KNOCKED UNCONSCIOUS? YES NO IF YES, WHY? _____

HAVE YOU EVER HAD A LAPSE OF MEMORY? YES NO IF YES, WHY? _____

HAVE YOU EVER HAD X-RAYS TAKEN? YES NO

HAVE YOU EVER SEEN A CHIROPRACTOR BEFORE? YES NO IF YES, WHO? _____

HOW LONG AGO? _____ WHY DID YOU DISCONTINUE CARE? _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS, VITAMINS, HERBS, MINERALS? YES NO

IF YES, PLEASE LIST THEM: _____

***THANK YOU FOR YOUR COOPERATION IN FILLING OUT THIS
FORM TO ENABLE US TO BETTER CARE FOR YOUR HEALTH
FIRST.***