Health First Chiropractic Clinic, P.C.
"Caring for Your Health First"

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Patient Registration and History

Today's Date: _____

Name: _____ Date of Birth: _____

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

Phone Number: _____/Alternate: _____ Type: _____

E-mail: _____ Social Security #: _____

Sex: M F Marital Status: Single Married Divorced Widowed

Occupation: _____ Employer: _____

Work Phone: _____

Insurance Company: _____ *Please give card to staff for a copy.*

Name of *Primary Insured:* _____ Date of Birth: _____

Relation to *Primary Insured:* _____

In case of emergency, please contact: _____

Relation to Patient: _____ Phone: _____

Is there a possibility this condition may be involved in a lawsuit, litigation, attorney, or other third party (E.g. Worker's Comp, Auto Claim, Personal Injury, etc.)? Yes No

If yes, please name: _____

Do you have a Primary Care Provider? Yes No If yes, please list: _____

Phone Number: _____

Office: _____

I authorize use of this form on all my insurance submissions. I authorize release of information to all my Insurance Companies. I understand that I am responsible for knowing my insurance coverage as I will be provided the most appropriate care deemed necessary without consideration or knowledge of my insurance plan. I understand a claim will be submitted to my insurance company as a courtesy. I understand that any services not covered are my responsibility. I understand I am responsible for my bill. I authorize Dr. Szagesh to act as my agent in helping me to obtain payment from my insurance company. I authorize payment directly 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 be adjusting me and discussing my conditions and treatments 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 or adjusting room.

I state that the above information is correct and adequate to the best of my knowledge.

Printed Patient Name

_____

Patient (or Patient Representative Signature) _____ Date _____

Printed Patient Representative Name (If applicable) _____ Relationship to Patient _____

Health First Chiropractic Witness _____ Date _____

Implemented 7-4-16

#_____

Family, Social, and Health History

Please Circle all the signs and symptoms you have or are concerned with on a **regular basis**. A complete history and understanding of your health status will help us to better facilitate care.

General Symptoms			
Wheezing	Fever	Night Sweats	Fainting
Dizziness	Nervousness	Convulsions	Fatigue
Loss of Weight	Numbness/Pain in arms/legs or hands/ feet	Headache of Migraine	Chills

Gastro-Intestinal			
Nausea	Poor Digestion	Hemorrhoids	Vomiting
Gall Bladder Trouble	Constipation/ Diarrhea	Pain over stomach	Belching or Gas
Colon Trouble	Liver Trouble	Excessive Hunger	Poor Appetite

Eye, Ear, Nose, and Throat			
Earache	Sinus Trouble	Poor Vision	Asthma
Sore Throat	Hoarseness	Nasal Obstruction	Nose Bleeds
Hoarseness	Enlarged Thyroid	Tonsillitis	Deafness

Genito-Urinary			
Frequent Urination	Painful Urination	Blood in Urine	Kidney Infection
Bed Wetting	Inability to Control Urine	Prostrate Trouble (Men Only)	

Muscles & Joints			
Weakness	Twitching (Spasms)	Stiff Neck	Back Pain
Swollen Joints	Tremors	Foot Trouble	Hernia

Cardiovascular			
Irregular Heartbeat	High or Low Blood Pressure	Pain over Heart	Varicose Veins
Poor Circulation	Swelling of ankles/ Edema	Heart Disease	History of Stroke

Skin		
Ace	Itching	Bruising Easily
Sensitive Skin	Hives	Eczema

Respiratory		
Chronic Cough	Spitting Blood	Spitting Phlegm
Chest Pain	Trouble Breathing	

Women Only			
Miscarriage	Painful Periods	Irregular Cycles	Hot Flashes
Cramps or Backaches	Pregnant (Due Date: _____)	Excessive Flow	Vaginal Discharge

Do you have/had any of the following?				
Diabetes	Chicken Pox	Multiple Sclerosis	Vaccinations	Gall Bladder
Anemia	Cancer (_____)	Mumps	Epilepsy	Thyroid
HIV/Aids	Lupus	Rheumatic Fever	Arthritis	Alcoholism
Polio/Measles	Tuberculosis	Sinus Surgery	Hernia	Stomach/Ulcer

Family History (Please list type)				
	Diabetes	Heart	Cancer	Arthritis
Mother				
Father				
Siblings	B, S	B, S	B, S	B, S

Work Activity
Sitting (__ Hrs/Day)
Standing (__ Hrs/Day)
Light Labor
Heavy Labor

Habits
Smoking (__ Packs/Day)
Alcohol (__ Drinks/Wk)
Caffeine (__ Cups/Day)
High Stress

Exercise
None
Light (__ Hrs/Wk)
Moderate (__ Hrs/Wk)
Heavy (__ Hrs/Wk)

List any accidents or falls: _____
List any surgeries, spinal taps or injections?_____:_____
Have you had any broken bones or fractures? Yes No If yes, list: _____
Has your social life been affected from this? Yes No If yes, list: _____
Have you previously seen a Chiropractor? Yes No If yes, whom? _____

How were you were referred to our office? _____

Medical Affidavit: I do attest, that the above information is correct and true to the best of my knowledge.

Patient Signature: _____ Date:_____

Reviewed & Consulted by (Physician Signature): _____

#_____

Implemented 7-4-2016