SHAW CHIROPRACTIC
REGISTRATION AND HISTORY

PATIENT INFORMATION

Date _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

Home Phone ( ) _____

Cell Phone ( ) _____

Date of Birth _____ Age _____

Sex ☐ Male ☐ Female

Social Security # _____

E-Mail _____

☐Married ☐Widowed ☐Single ☐Minor

☐Separated ☐ Divorced ☐Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone ( ) _____

Spouse's Name _____

Date of Birth _____

Spouse's Employer _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

Phone Number ( ) _____

Whom may we thank for referring you?

_____

MEDICATIONS

_____

_____

_____

_____

ALLERGIES

_____

_____

_____

_____

VITAMINS/HERBS/MINERALS

_____

_____

_____

_____

INSURANCE INFORMATION

Who is responsible for this account? _____ Relationship to patient _____

Policy Holder _____ Date of Birth _____ Social Security # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage and assign all current benefits, if any, directly to Shaw Chiropractic, PC, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company(ies). I authorize the use of my signature on all insurance submissions.

Shaw Chiropractic, PC, may use my healthcare information and may disclose such information to my 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.

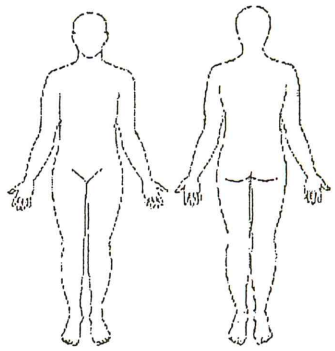
_____ _____ _____ _____

(Signature of patient, or parent/guardian) (Printed name of patient or parent/guardian) (Relationship to patient) (Date)

PATIENT CONDITION

Present Complaint?_____
When did your symptoms appear?_____
Type of condition? ◻ New Injury ◻ Reoccurrence ◻ Constant
Type of pain: ◻Aching ◻Burning ◻Numbness ◻Sharp ◻Shooting
◻Stabbing ◻Stiffness ◻Throbbing ◻Tingling
How did your symptoms occur? ◻Gradually ◻Slip and Fall
◻Sports Injury ◻Lifting Injury ◻Unknown
What positions increase your pain? ◻Sitting ◻Standing ◻Walking
◻Lying down ◻Bending ◻Lifting ◻None
What positions decrease your pain? ◻Sitting ◻Standing ◻Walking
◻Lying down ◻Bending ◻Lifting ◻None
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____
How often do you have this pain? ◻Occasionally (25% of day) ◻Intermittent (50% of day)
◻Frequent (75% of day) ◻Constant (100% of day)

Mark an 'X' on the body
to show where you are having symptoms



HEALTH HISTORY

What treatment have you already received for your condition? ◻ Medication ◻Surgery ◻Chiropractic ◻Physical Therapy
◻ None ◻Other _____
Name of other doctor(s) who have treated you for your condition_____
Date of last: Physical Exam _____ Spinal Exam _____ Spinal X-Ray_____
Chest X-Ray _____ MRI, CT-Scan, Bone Scan _____
Are you pregnant? ◻Yes ◻No Due Date_____ Number of children_____ Number of cesarean sections_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Arthritis	◻Yes ◻No	Hernia	◻Yes ◻No	Measles	◻Yes ◻No	Liver Disease	◻Yes ◻No
Fractures	◻Yes ◻No	Breast Lump	◻Yes ◻No	Miscarriage	◻Yes ◻No	Multiple Sclerosis	◻Yes ◻No
Gout	◻Yes ◻No	Cancer	◻Yes ◻No	Mononucleosis	◻Yes ◻No		
Herniated Disc	◻Yes ◻No	Emphysema	◻Yes ◻No	Mumps	◻Yes ◻No	Parkinson's Disease	◻Yes ◻No
Migraine Headaches	◻Yes ◻No	Tumors/Growth	◻Yes ◻No	Pneumonia	◻Yes ◻No		
		AIDS/HIV	◻Yes ◻No	Rheumatic Fever	◻Yes ◻No	Polio	◻Yes ◻No
Osteoporosis	◻Yes ◻No	Alcoholism	◻Yes ◻No			Prostate Problem	◻Yes ◻No
Pinched Nerve	◻Yes ◻No	Allergy Shots	◻Yes ◻No	Scarlet Fever	◻Yes ◻No		
Prosthesis	◻Yes ◻No	Anemia	◻Yes ◻No	Suicide Attempt	◻Yes ◻No	Psychiatric Care	◻Yes ◻No
Rheumatoid Arthritis	◻Yes ◻No	Anorexia	◻Yes ◻No	Tonsillitis	◻Yes ◻No		
		Appendicitis	◻Yes ◻No	Tuberculosis	◻Yes ◻No	Thyroid Problem	◻Yes ◻No
Bleeding Disorders	◻Yes ◻No	Bronchitis	◻Yes ◻No	Typhoid Fever	◻Yes ◻No		
		Bulimia	◻Yes ◻No	Ulcers	◻Yes ◻No	Other	◻Yes ◻No
Diabetes	◻Yes ◻No	Cataracts	◻Yes ◻No	Vaginal Infection	◻Yes ◻No	_____	
Heart Disease	◻Yes ◻No	Chemical Dependency	◻Yes ◻No			_____	
High Cholesterol	◻Yes ◻No			Venereal Disease	◻Yes ◻No	_____	
		Chicken Pox	◻Yes ◻No				
Pacemaker	◻Yes ◻No	Glaucoma	◻Yes ◻No	Whooping Cough	◻Yes ◻No		
Stroke	◻Yes ◻No	Gonorrhea	◻Yes ◻No				
Asthma	◻Yes ◻No	Hepatitis	◻Yes ◻No	Goiter	◻Yes ◻No		
Epilepsy	◻Yes ◻No	Herpes	◻Yes ◻No	Kidney Disease	◻Yes ◻No		

EXERCISE ◻_____

◻None
◻Light
◻Moderate
◻Heavy
◻Walk/Jog
◻Run
◻Aerobics
◻Weights
◻Sports

WORK ACTIVITY

◻Sitting
◻Standing
◻Light Labor
◻Heavy Labor

HABITS

◻Smoking Packs/Day _____
◻Alcohol Drinks/Week _____
◻Caffeine Cups/Day _____
◻High Stress Level - ◻Work ◻Home
◻Diet

SLEEPING HABITS

I sleep approx.
◻< 4 hrs/night
◻4-6 hrs/night
◻7-9 hrs/night
◻>10 hrs/night

I sleep on my
◻Back
◻Stomach
◻Side

INJURIES/SURGERIES

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		