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. Alan 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.

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.

___ appendicitis
___ diabetes
___ chicken pox
___ multiple sclerosis
___ vaccinations
___ gall bladder
___ rectal surgery
___ anemia
___ cancer _________________
___ mumps
___ epilepsy
___ tonsillectomy
___ appendectomy
___ thyroid
___ heart disease
___ HIV/aids
___ measles
___ rheumatic fever
___ tubes in ears
___ female surgery __________________
___ back operations _________________
___ arthritis
___ alcoholism
___ polio
___ tuberculosis
___ sinus surgery
___ hernia
___ stomach/ulcer

EXERCISE
___ none
___ moderate
___ daily
___ heavy

WORK ACTIVITY
___ sitting hrs/day _____
___ standing hrs/day _____
___ light labor
___ heavy labor

HABITS
___ smoking packs/day ________
___ alcohol drinks/week _______
___ caffeine cups/day __________
___ high stress reason ____________

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: ____

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