Chandler Chiropractic Registration

Date_____

Patient Name_____
Last First M

Street Address_____

City_____ State_____ Zip_____

Sex (Assigned at Birth) _____ Gender Identity_____ Sexual Orientation_____

Age_____ Birth Date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #_____ Primary Phone # _____

Email Address _____

Insured's Name_____
Last First M

Your Relationship to the Insured_____ (Self, Spouse, Child, Other)

Condition Related To: ☐ Illness ☐ Auto Accident ☐ Work Injury ☐ Injury at Home

Your Employer:

Company Name: _____ Occupation_____

Medical Legal Information:

Referred By _____ Family Physician _____

Attorney Name _____ Address_____

Phone_____

Patient Agreement:

Assignment and Release

I, the undersigned, have insurance with _____
Name or Insurance Company

And assign directly to Chandler Chiropractic LLC all Medical Benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I hereby authorize Chandler Chiropractic LLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Patient/Guardian **Date**

I have received the ***HIPPA Notice of Privacy Practices*** and have been provided an opportunity to review it.

Signature _____ Date_____

Chiropractic Health Questionnaire

Date _____

Patient Name _____ Birthdate _____

Reason for visit _____

Have you been treated for this problem before? Yes ___ No ___

If yes, by: Physician ___ Chiropractor ___ Physical Therapist ___ Specialist ___

When did your Symptoms appear? _____ Are your symptoms getting worse? Yes ___ No ___

Is the problem Constant or does it come and go? _____

Does it interfere with your: Work ___ Sleep ___ Daily Routine___ Sitting ___ Walking ___

Your Occupation: _____

Are you taking Muscle Relaxers ___ Pain Killers ___ Over the Counter Meds ___ All Natural ___

Date of Last: Physical Exam _____ X-Ray _____ MRI/CT _____

Sleep Hours_____ Per Night Do You Sleep on your: Side ___ Back ___ Stomach ___

Conditions

___ Arthritis ___ Cancer ___ Diabetes ___ Fractures

___ Gout ___ Heart ___ Hernia ___ Migraines

___ Osteoporosis ___ Osteoarthritis ___ Rheumatoid Arthritis

___ Pacemaker ___ Stroke ___ Tumors, Growths ___ Other

General Symptoms

___ Bruise Easily ___ Depression ___ Difficulty Sleeping

___ Fainting ___ Headache ___ Loss of Sleep ___ Loss of Weight

___ Anxiety ___ Loss of Bladder and Bowel Control ___ Chest Pain

___ Are you Pregnant?

Neck, Back, Extremities

___ Pain in Neck ___ Neck Stiffness ___ Neck Weakness ___ Pinched Nerve in Neck

___ Muscles Spasms in Neck ___ ***L*** Side of Neck ___ ***R*** Side of Neck

___ Pain in Shoulder ___ ***L*** Shoulder ___ ***R*** Shoulder ___ Mid Back Pain

___ Mid Back Stiffness ___ Pain Between Shoulder Blades ___ Muscles Spasm Mid Back

___ Pain in Arm ___ Pain in Elbow ___ Pain in Forearm ___ Pain in Hand

_____ Pins and Needles, Numbness, Weakness in Arm or Hand

Chiropractic Health Questionnaire

Neck, Back, Extremities

___ Low Back Pain ___ Low Back Stiffness ___ Low Back Weakness

___ Pinched Nerve in Low Back ___ Muscles Spasms in Low Back

___ Pain in Buttocks ___ Pain in ***L*** Hip ___ Pain in ***R*** Hip

___ Pain in ***L*** Leg ___ Pain in ***R*** Leg ___ Pain in ***L*** Knee ___ Pain in ***R*** Knee

___ Pain in ***L*** Ankle ___ Pain in ***R*** Ankle ___ Pain in ***L*** Foot ___ Pain in ***R*** Foot

List of Back Surgeries: _____

_____

Other Symptoms or conditions not listed here that might be pertinent to your care:

_____

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Chandler or any members of his staff responsible for any omissions or errors that I may have made in the completion of this form.

_____ _____

Patient Signature Date

_____ _____

Doctor Signature After Reviewing Date