chandler chiropractic

3681 Leaphart Rd Ste D, West Columbia, SC 29169
(803) 796-0855

# patient registration

Please fill in everything that applies to you.

TODAY'S DATE MM/DD/YYYY

## PATIENT

LAST NAME | FIRST NAME | MIDDLE INITIAL

STREET ADDRESS

CITY | STATE | ZIP

SEX ASSIGNED AT BIRTH | GENDER IDENTITY | SEXUAL ORIENTATION

AGE | BIRTH DATE MM/DD/YYYY | MARITAL STATUS

◯ Single ◯ Married ◯ Widowed ◯ Separated ◯ Divorced

SOCIAL SECURITY # | PRIMARY PHONE | EMAIL ADDRESS

## INSURANCE

INSURED'S LAST NAME | INSURED'S FIRST NAME | MIDDLE INITIAL

YOUR RELATIONSHIP TO THE INSURED

◯ Self ◯ Spouse ◯ Child ◯ Other

## YOUR CONDITION AND EMPLOYER

CONDITION RELATED TO

☐ Illness ☐ Auto accident ☐ Work injury ☐ Injury at home

EMPLOYER (COMPANY NAME) | OCCUPATION

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# patient registration, continued

## MEDICAL-LEGAL INFORMATION

REFERRED BY

FAMILY PHYSICIAN

ATTORNEY NAME if applicable

ATTORNEY PHONE

ATTORNEY ADDRESS

## ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED, HAVE INSURANCE WITH name of 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 OR GUARDIAN

DATE MM/DD/YYYY

Type your full legal name. Your typed name serves as your electronic signature.

## NOTICE OF PRIVACY PRACTICES

I have received the HIPAA Notice of Privacy Practices and have been provided an opportunity to review it. If you are completing these forms online, a copy of the Notice will be available to you at your first appointment.

SIGNATURE

DATE MM/DD/YYYY

Type your full legal name. Your typed name serves as your electronic signature.

### HOW TO SEND THESE FORMS

01 Fill in all four pages and type your name on every signature line.

02 Save the file — in most apps, File › Save, or the download or share icon on a phone.

03 Reply to the email these forms came with and attach the saved file. Or bring it, on your phone or printed, to your first visit.

**Questions? Call (803) 796-0855.**

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# chiropractic health questionnaire

Tell us what brings you in. Check everything that applies.

**TODAY'S DATE** MM/DD/YYYY

**PATIENT NAME**

**BIRTH DATE** MM/DD/YYYY

**REASON FOR VISIT**

**TREATED FOR THIS BEFORE?**

◯ Yes ◯ No

**IF YES, BY**

☐ Physician ☐ Chiropractor ☐ Physical therapist ☐ Specialist

**WHEN DID SYMPTOMS APPEAR?**

**GETTING WORSE?**

◯ Yes ◯ No

**IS THE PROBLEM**

◯ Constant ◯ Comes and goes

**DOES IT INTERFERE WITH YOUR**

☐ Work ☐ Sleep ☐ Daily routine ☐ Sitting ☐ Walking

**ARE YOU TAKING**

☐ Muscle relaxers ☐ Pain killers ☐ Over-the-counter meds ☐ All natural

**LAST PHYSICAL EXAM** MM/DD/YYYY

**LAST X-RAY** MM/DD/YYYY

**LAST MRI / CT** MM/DD/YYYY

**SLEEP HOURS PER NIGHT**

**YOUR OCCUPATION**

**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 ☐ Chest pain
☐ Loss of bladder or bowel control

**COULD YOU BE PREGNANT?**

◯ Yes ◯ No ◯ Not sure ◯ Does not apply

**IF YES, HOW MANY WEEKS?**

**FIRST DAY OF LAST PERIOD** MM/DD/YYYY

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# health questionnaire, continued

## NECK, BACK, EXTREMITIES

### NECK, SHOULDERS AND ARMS

- [ ] Pain in neck
- [ ] Neck stiffness
- [ ] Neck weakness
- [ ] Pinched nerve in neck
- [ ] Muscle spasms in neck
- [ ] Left side of neck
- [ ] Right side of neck
- [ ] Pain in shoulder
- [ ] Left shoulder
- [ ] Right shoulder
- [ ] Mid back pain
- [ ] Mid back stiffness
- [ ] Pain between shoulder blades
- [ ] Muscle spasm mid back
- [ ] Pain in arm
- [ ] Pain in elbow
- [ ] Pain in forearm
- [ ] Pain in hand
- [ ] Pins and needles, numbness or weakness in arm or hand — where?

### LOW BACK, HIPS AND LEGS

- [ ] Low back pain
- [ ] Low back stiffness
- [ ] Low back weakness
- [ ] Pinched nerve in low back
- [ ] Muscle spasms in low back
- [ ] Pain in buttocks
- [ ] Pain in left hip
- [ ] Pain in right hip
- [ ] Pain in left leg
- [ ] Pain in right leg
- [ ] Pain in left knee
- [ ] Pain in right knee
- [ ] Pain in left ankle
- [ ] Pain in right ankle
- [ ] Pain in left foot
- [ ] Pain in right foot

### LIST OF BACK SURGERIES

### OTHER SYMPTOMS OR CONDITIONS NOT LISTED 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 MM/DD/YYYY

Type your full legal name. Your typed name serves as your electronic signature.

OFFICE USE ONLY

DOCTOR SIGNATURE AFTER REVIEWING

DATE MM/DD/YYYY