

# Shoreline Family Chiropractic & Wellness Registration & History



## Patient Information

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ How did you hear about our office? \_\_\_\_\_  
Patient: \_\_\_\_\_ D.O.B \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  M  F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Martial Status:  Single  Married  Divorced  Widowed  Other  
Social Security #: \_\_\_\_\_ Email: \_\_\_\_\_  
Mobile/Cell #: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Occupation \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_  
What are the best ways to contact you? \_\_ Home\_\_ Cell\_\_ Work \_\_ Text\_\_ Email \_\_ Facebook \_\_ Other:

### IN CASE OF EMERGENCY CONTACT:

Name: \_\_\_\_\_ Home phone: \_\_\_\_\_ Cell/Work: \_\_\_\_\_ Relationship: \_\_\_\_\_

## Please Complete

**\*\*Be sure to provide the front desk with ALL health insurance and Photo IDs\*\***

### ASSIGNMENT & RELEASE

I, understand, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Shoreline Family Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

## Accident Information

Is this condition due to an accident? **YES NO** Type of Accident: **Auto Work Home Other**

Injury Date \_\_\_\_\_ Auto Insurance Information (if injury related to Auto Accident):

Company: \_\_\_\_\_ Policy : \_\_\_\_\_

**\*Are you pregnant**  Yes  No **Due Date:** \_\_\_\_\_ **Comments:** \_\_\_\_\_

*Chiropractic is the detection and correction of Vertebral Subluxations (spinal mis-alignment that cause disruption to your nervous system) to maintain proper health. Subluxations are caused by physical, chemical, and emotional stressors to the body. Please complete the section below so that we may have a better understanding of your health status and the stress that your body has previously had or currently is experiencing.*

**Please turn over...**

Primary reason(s) for visit: \_\_\_\_\_

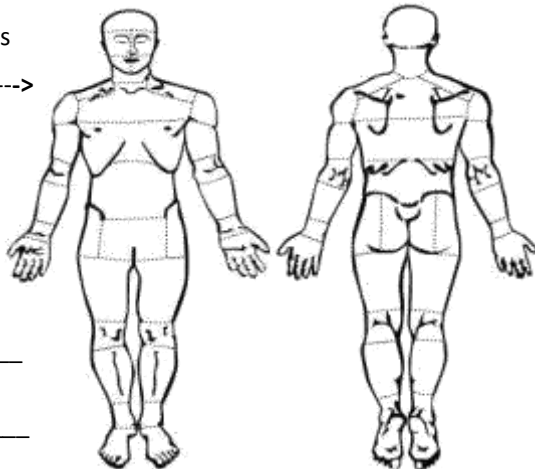
How did this occur?: \_\_\_\_\_

Symptoms appeared:  Gradually  Suddenly Has this happened before? Y N If yes, When \_\_\_\_\_

How long have you had this issue? \_\_\_\_\_ Years / Months / Weeks / Days

Mark an X on the picture to the right where you are having pain or discomfort --->

Type of pain: Aching Burning Diffused Dull Numbness Sharp  
Shooting Throbbing Tightness Tingling



How frequently do you have this pain? (Check one below):

Constant Frequent Intermittent Occasional

Symptoms are aggravated by: \_\_\_\_\_

Symptoms are reduced by: \_\_\_\_\_

Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10

(0= no pain 10= worst pain imaginable)

Why is important to fix this issue? \_\_\_\_\_

**DAILY ACTIVITIES (111)** What kind of effect does your condition have on the following? Check all that apply.

- Bathing  No Effect  Painful (can do)  Painful (limits)  Unable to Perform
- Carrying Groceries  No Effect  Painful (can do)  Painful (limits)  Unable to Perform
- Climbing Stairs  No Effect  Painful (can do)  Painful (limits)  Unable to Perform
- Computer Use  No Effect  Painful (can do)  Painful (limits)  Unable to Perform
- Concentration  No Effect  Painful (can do)  Painful (limits)  Unable to Perform
- Dressing  No Effect  Painful (can do)  Painful (limits)  Unable to Perform
- Driving  No Effect  Painful (can do)  Painful (limits)  Unable to Perform
- Exercising  No Effect  Painful (can do)  Painful (limits)  Unable to Perform
- Hobbies  No Effect  Painful (can do)  Painful (limits)  Unable to Perform
- Household Chores  No Effect  Painful (can do)  Painful (limits)  Unable to Perform
- Lifting Children  No Effect  Painful (can do)  Painful (limits)  Unable to Perform
- Pet Care  No Effect  Painful (can do)  Painful (limits)  Unable to Perform
- Playing  No Effect  Painful (can do)  Painful (limits)  Unable to Perform
- Sexual Activities  No Effect  Painful (can do)  Painful (limits)  Unable to Perform
- Sitting / Standing  No Effect  Painful (can do)  Painful (limits)  Unable to Perform
- Sleep  No Effect  Painful (can do)  Painful (limits)  Unable to Perform
- Yard Work  No Effect  Painful (can do)  Painful (limits)  Unable to Perform
- Walking  No Effect  Painful (can do)  Painful (limits)  Unable to Perform

**Family Hx (112) :**    Cancer    Heart Dz    Osteoporosis    Arthritis    Obseity    Diabetes    Other:

Please list ALL Meds and reason for taking them (113): \_\_\_\_\_

List Prior Surgeries(114) \_\_\_\_\_

Exercise: \_\_\_\_\_ Hobbies \_\_\_\_\_

Glasses of alcohol weekly: \_\_\_\_\_ Smoking Amount Daily \_\_\_\_\_ Coffee Amount Daily: \_\_\_\_\_ Soda Amount Daily: \_\_\_\_\_

Any additional information you believe would be helpful for us to know: \_\_\_\_\_

# Health History " In the past 12 months I have experienced.....

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Recent accident<br><input type="checkbox"/> Muscle Spasms<br><input type="checkbox"/> Numbness<br><input type="checkbox"/> Tingling<br><input type="checkbox"/> Radiating pain<br><input type="checkbox"/> Headaches<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Anxiety<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Vision problems<br><input type="checkbox"/> Nausea<br><input type="checkbox"/> Restriction movement<br><input type="checkbox"/> Sleeping problems<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Breathing problems<br><input type="checkbox"/> High blood pressure<br><input type="checkbox"/> Hearing problems<br><input type="checkbox"/> Convulsions<br><input type="checkbox"/> Heartburn<br><input type="checkbox"/> Acid reflux<br><input type="checkbox"/> Digestive problems<br><input type="checkbox"/> Menstrual problems<br><input type="checkbox"/> Sinus disorder<br><input type="checkbox"/> Shoulder problems<br><input type="checkbox"/> Hip leg discomfort<br><input type="checkbox"/> Jaw/mouth problems | <input type="checkbox"/> Born with bone or joint disorder<br><input type="checkbox"/> Degenerative arthritis<br><input type="checkbox"/> Rheumatoid arthritis<br><input type="checkbox"/> Compression fracture<br><input type="checkbox"/> Heart attack<br><input type="checkbox"/> History of stroke<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Gout<br><input type="checkbox"/> Lupus<br><input type="checkbox"/> Ankylosing spondylitis<br><input type="checkbox"/> Immune suppression<br><input type="checkbox"/> Use of steroid medications<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Hepatitis B or HIV infection<br><input type="checkbox"/> Multiple Sclerosis<br><input type="checkbox"/> Thyroid or hormone disorder<br><input type="checkbox"/> Poor balance<br><input type="checkbox"/> Blurred or double vision<br><input type="checkbox"/> Memory loss after injury<br><input type="checkbox"/> Unexplained weight loss<br><input type="checkbox"/> Recent progressive muscle weakness<br><input type="checkbox"/> Shaking<br><input type="checkbox"/> Recent fever over 103 degrees<br><input type="checkbox"/> Loss of bowel or bladder control | <input type="checkbox"/> Neck pain with difficulty swallowing<br><input type="checkbox"/> Extreme neck stiffness with pain<br><input type="checkbox"/> Shock when moving neck, back, arms or legs<br><input type="checkbox"/> Leg pain worsens with exercise<br><input type="checkbox"/> Numbness of inner thighs<br><input type="checkbox"/> Back pain with urinary problems<br><input type="checkbox"/> Severe pain that interrupts sleep<br><input type="checkbox"/> Constant pain that doesn't improve by changing position or by lying down<br><br><b><input type="checkbox"/> Your CHILDREN/INFANTS</b><br><input type="checkbox"/> Colic<br><input type="checkbox"/> Sleep Problems<br><input type="checkbox"/> Ear Infections<br><input type="checkbox"/> Reflux<br><input type="checkbox"/> Bed Wetting<br><input type="checkbox"/> ADD/ADHD<br><input type="checkbox"/> Scoliosis<br><input type="checkbox"/> Allergies / Sinuses<br><input type="checkbox"/> Poor Posture<br><input type="checkbox"/> Traumatic Birth<br><input type="checkbox"/> Headaches or Migraines<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Autism Spectrum Disorder<br><input type="checkbox"/> Lack of Motivation/ Energy<br><input type="checkbox"/> Weight Gain/Loss |
|--|---|---|

Please rate your level of commitment to resolving this condition and improving your health:

0=no commitment      **0 1 2 3 4 5 6 7 8 9 10**      10=full commitment

If less than 10, what limits your commitment:  TIME  MONEY  OTHER \_\_\_\_\_

I rate my health over the past 5 years as: \_\_\_ Improved \_\_\_ Same \_\_\_ Worse

Assuming we can help you, how would you like to address your health?

\_\_\_ Symptom Relief Only (Does NOT correct the cause of the problem)

\_\_\_ Maximum Correction (Corrects the cause of the problem, leading to wellness care)

Primary Care Physician: \_\_\_\_\_ Date of last Exam: \_\_\_\_\_

Have you received chiropractic care before? YES NO Name of D.C. \_\_\_\_\_ Reason For Stopping \_\_\_\_\_

Date of Last: Spinal Exam: \_\_\_\_\_ Dental Exam: \_\_\_\_\_ Chest X ray: \_\_\_\_\_ Urine Test: \_\_\_\_\_ MRI/CAT Scan, Bone Scan: \_\_\_\_\_

Injuries/Surgeries you have had: LIST ALL with dates: \_\_\_\_\_

***By signing below, I certify that ALL information provided on these forms is true to the best of my knowledge.***

Print Name: \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_