BEREZNY CHIROPRACTIC PATIENT HISTORY AND REGISTRATION FORM

Name: _____ Date: _____ Acct #: _____

PATIENT CONDITION (please print)

Major Complaint: _____

When did your symptom(s) first appear? _____

Have you had this or a similar condition in the past? _____ When? _____

The condition is getting: Better ☐ Worse ☐ Unchanged ☐

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ____

Other Complaint(s): _____

Type of pain: Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐

Burning ☐ Tingling ☐ Stiffness ☐ Swelling ☐ Cramping ☐

How often does the pain occur? _____ Time of day? _____

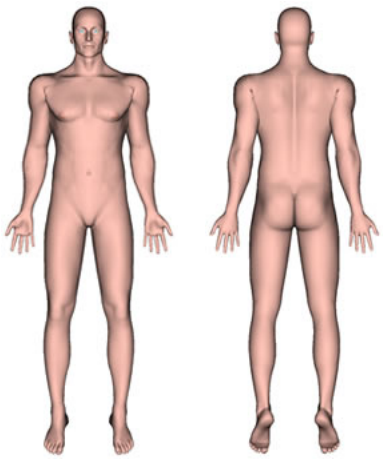
Does it interfere with: Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐

Activities that are painful: Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐

What (if anything) makes it feel better? _____

What medication(s) are you presently taking? _____

Mark an X on the picture(s) below where you have pain, numbness or tingling:



HEALTH HISTORY (please indicate all that apply using this code: P = Past C = Current)

What treatment(s) have you received for your condition? Medication ☐ Surgery ☐ Physical Therapy ☐ Other Chiropractic Services ☐ Other ☐ None ☐

SYMPTOMS:

Head

- Headache
- Migraine(s)
- Sinus (allergy)
- Dizziness/Lightheaded/Fainting
- Loss of Balance
- Ear Infection(s)
- Blurred Vision

Neck

- Neck Pain
- Neck Stiffness/Spasms
- Grinding/Popping Sounds

Shoulders

- Shoulder Pain L or R
- Arthritis/Bursitis in Shoulder L or R
- Stiffness/Spasms in Shoulder L or R
- Unable to Raise Arm L or R

Mid-Back

- Mid-Back Pain
- Mid-Back Stiffness/Spasms

Chest

- Chest Pain
- Irregular Heartbeat
- Asthma/Shortness of Breath

Arms and Hands

- Upper/Lower Arm Pain L or R
- Elbow Pain L or R
- Wrist Pain L or R
- Hand Pain/Numbness L or R
- Finger Pain/Numbness L or R
- Cold Hand/Swollen Finger(s) L or R
- Arthritis in Arm/Hand L or R
- Loss of Grip Strength L or R

Abdomen

- Heartburn/Reflux
- Constipation/Diarrhea
- Nausea

Low Back

- Herniated/Bulging Disc(s)
- Low Back Pain
- Arthritis/Disc Degeneration
- Low Back Stiffness/Spasms

General

- Fatigue
- High Blood Pressure
- Depression
- Cancer
- Diabetes
- Sleep Loss
- Weight Loss/Gain

Hips, Legs and Feet

- Hip Pain L or R
- Upper/Lower Leg Pain L or R
- Knee Pain L or R
- Ankle Pain L or R
- Foot Pain/Numbness L or R
- Swollen Foot/Ankle L or R
- Cold Foot L or R

Women Only

- Menstrual Cramps/Pain
- Hysterectomy
- Menopausal Symptoms
- Birth Control: Type _____

ARE YOU OR DO YOU THINK YOU MIGHT BE PREGNANT? Yes ◯ No ◯

PLEASE INITIAL HERE _____

Men Only

- Prostate Condition

Remarks: _____

PATIENT INFORMATION (please print)

Name _____

Address _____

City, State, ZIP _____

Phone _____ Mobile _____

E-Mail _____

Male ☐ Female ☐ Birthdate _____ SS # _____

Marital Status _____ Number of Children _____

Occupation _____

Employer _____

Employer Address _____

Employer City, State, ZIP _____

Employer Phone _____

Spouse's Name _____

Male ☐ Female ☐ Birthdate _____ SS # _____

Spouse's E-Mail _____

Spouse's Occupation _____

Spouse's Employer _____

Spouse's Employer Address _____

Spouse's Employer City, State, ZIP _____

Spouse's Employer Phone _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION (please print)

Do you have health insurance? Yes ☐ No ☐

Do you have secondary insurance? Yes ☐ No ☐

Please provide the chiropractic assistant with a copy of your card(s).

Assignment & Release

I, the undersigned certify that I (or my dependent) have insurance coverage with

_____

and assign directly to Dr. Berezny all insurance benefits, if any, otherwise payable tome 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 use of this signature on all insurance submissions.

Signature

_____

Relationship _____ Date: _____

ACCIDENT INFORMATION (please print)

Type of Accident Auto ☐ Work ☐ Other Trauma ☐

Please Describe _____

Attorney's Name, Address & Contact Information _____

PATIENT EXPECTATION

Which are you interested in?

☐ Relief of symptoms/pain management ☐ Family Wellness Care

☐ Personal Wellness Care ☐ Better health with Chiropractic

EXERCISE

☐ None ☐ Light

☐ Daily ☐ Moderate

☐ Weekly ☐ Heavy

WORK ACTIVITY

☐ Sitting ☐ Light Labor

☐ Standing ☐ Moderate Labor

☐ Bending ☐ Heavy Labor

HABITS

☐ Smoking ☐ High Stress

☐ Alcohol ☐ Caffeine Drinks

PATIENT STATEMENT

I understand and agree that all services rendered to me (or my dependent) are charged directly to me and that I am personally responsible for payment, whether or not I have insurance. I understand that if I suspend or terminate treatment, any fees for professional services already rendered to me (or my dependent) will be immediately due and payable.

Signature _____ Date: _____