1134 Front Street
Buffalo IA 52728

Phone 563-823-8836
Fax 563-823-8305

DocSide Chiropractic

CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Patient Name_____
Last First MI
Address _____
City_____State_____Zip_____
Home Phone _____Cell Phone _____
Work Phone_____ext_____
E-Mail _____
Gender __Male ___Female SS# _____
Birthdate _____ Age ___ Race_____
__Married __Widowed __Divorced __Separated
__Single __Partnered for___ years __Minor
Patient Employer/School _____
Occupation _____
Employer/School Address
_____
Spouse's Name _____
Spouse's Birthdate_____ Age ___
Employer_____
Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Primary Insurance
Company_____
Subscribers Name _____Birthdate_____
Relationship to Patient_____
ID_____Group Number_____

Secondary Insurance
Company_____
Subscribers Name_____Birthdate_____
Relationship to Patient_____
ID_____Group Number_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with_____and assign directly to
Name of Insurance Company(ies)
Dr. Colleen Reed-Dittmar 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 and agree to pay any co-payments at time of service. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my health care information and may disclose such information the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.
I understand that In the event that my insurance company will not assign benefits directly to the provider that I will be responsible for the full price of the visit, payable to DocSide Chiropractic, LLC.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 EMERGENCY CONTACT INFORMATION

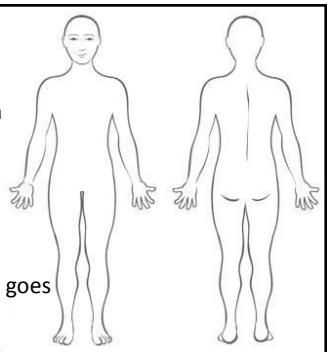
Name_____ Relationship_____
Home Phone_____ Work Phone_____

4 ACCIDENT INFORMATION

Is condition due to an accident? __Yes __No
Type of accident __Auto __Work __Home __Other
To whom have you made a report of your accident?
__Auto Insurance __Employer __Worker Comp. __Other

5 PATIENT CONDITION

Reason for Visit_____
When did your symptoms begin?_____ Is it getting progressively worse? __Yes __No __Unknown
Mark an X on the picture where you continue to have pain, numbness, or tingling.
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____
Type of pain: __Sharp __Dull __Throbbing __Numbness __Aching __Shooting
__Burning __Tingling __Cramps __Stiffness __Swelling __Other
How often do you have this pain?_____ __The pain is constant __The pain comes and goes
Does it interfere with your __Work __Sleep __Daily Routine __Recreation
Activities or movements that are painful to perform __Sitting __Standing __Walking __Bending __Lying Down



FAMILY HISTORY

Family history of Cancer, Disease, Stroke, Cardio, Etc...?
____
____
____

Please list family member(s):
____
____
____

HEALTH HISTORY

What treatment have you already received for your *current* condition?

__Medication __Surgery __Physical Therapy __Chiropractic Services __None __Other________________________

Name and address of other doctor(s) who have treated you for your *current* condition____

____

Date of Last ·πwl·èψψψψψψψψψψψψψ!ℕŜl· 2Ŧ ·πwl·èψψψψψψψψψψψψψψψψψψψψψψψ

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Please mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV __Yes __No	Diabetes __Yes __No	Liver Disease __Yes __No	Rheumatoid Arthritis __Yes __No
Alcoholism __Yes __No	Emphysema __Yes __No	Measles __Yes __No	Rheumatic Fever __Yes __No
Allergy Shots __Yes __No	Epilepsy __Yes __No	Migraine Headaches __Yes __No	Scarlet Fever __Yes __No
Anemia __Yes __No	Fractures __Yes __No	Miscarriage __Yes __No	S.T.D. __Yes __No
Anorexia __Yes __No	Glaucoma __Yes __No	Mononucleosis __Yes __No	Stroke __Yes __No
Appendicitis __Yes __No	Goiter __Yes __No	Multiple Sclerosis __Yes __No	Suicide Attempt __Yes __No
Arthritis __Yes __No	Gonorrhea __Yes __No	Mumps __Yes __No	Thyroid Problem __Yes __No
Asthma __Yes __No	Gout __Yes __No	Osteoporosis __Yes __No	Tonsillitis __Yes __No
Bleeding Disorders __Yes __No	Heart Disease __Yes __No	Pacemaker __Yes __No	Tuberculosis __Yes __No
Breast Lump __Yes __No	Hepatitis __Yes __No	Parkinson's Disease __Yes __No	Tumors, Growths __Yes __No
Bronchitis __Yes __No	Hernia __Yes __No	Pinched Nerve __Yes __No	Typhoid Fever __Yes __No
Bulimia __Yes __No	Herniated Disk __Yes __No	Pneumonia __Yes __No	Ulcers __Yes __No
Cancer __Yes __No	Herpes __Yes __No	Polio __Yes __No	Vaginal Infections __Yes __No
Cataracts __Yes __No	High Blood Pressure __Yes __No	Prostate Problem __Yes __No	Whooping Cough __Yes __No
Chemical Dependency __Yes __No	High Cholesterol __Yes __No	Prosthesis __Yes __No	Other ____________________
Chicken Pox __Yes __No	Kidney Disease __Yes __No	Psychiatric Care __Yes __No	________________________

EXERCISE
__None
__Moderate
__Daily
__Heavy

SMOKING STATUS (Circle one and fill in ages if applicable)

Never Smoker Former Smoker (Age started____ Age Quit____) Current Every Day Smoker (Age Started____)
Current Some Day Smoker (Age Started____)

ALCOHOL INTAKE (Circle One)

None Social Drinker Weekend Drinker Every Day Drinker

HOBBIES (Circle All That Apply)

Sports Gardening Fishing Crafts Dancing

Injuries/Surgeries you have had	Description	Date
Falls	______________________	__________
Head Injuries	______________________	__________
Broken Bones	______________________	__________
Dislocations	______________________	__________
Surgeries	______________________	__________

MEDICATIONS	START DATE	DOSAGE	FREQUENCY
__________	__________	__________	__________
__________	__________	__________	__________
__________	__________	__________	__________
__________	__________	__________	__________
__________	__________	__________	__________
__________	__________	__________	__________

ALLERGIES	REACTION
__________	__________
__________	__________
__________	__________
__________	__________
__________	__________
__________	