

# PATIENT REGISTRATION AND HISTORY

<b>1</b>	<b>PATIENT INFORMATION</b>
Date: _____	
Name: _____ <small>Last Name First Name Initial</small>	
Address: _____ _____	
Home Phone #: _____	
Work Phone #: _____	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F Age: _____ Birth date: _____	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Social Security #: _____	
<i>IN CASE OF AN EMERGENCY, CONTACT</i>	
Name: _____	
Relationship: _____	
Home Phone #: _____	
Work Phone #: _____	
Occupation: _____	
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time Approx. Hours/week _____	
Employer: _____	
Employer Address: _____ _____	
Employer Phone #: _____	
Is condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of accident: <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other	

<b>2</b>	<b>INSURANCE INFORMATION</b>
<u>Health Insurance:</u>	
Insurance Co.: _____	
Phone #: _____	
Policyholder name: _____	
Relationship to policyholder: _____	
Policy #: _____	
Group #: _____	
 <i>Complete the following if injury is related to work injury.</i>	
<u>Worker's Compensation:</u>	
Has this injury been reported? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Insurance Co.: _____	
Address: _____ _____	
Phone #: _____	
Policy #: _____	
Claim #: _____	
Name of Claim Adjuster: _____	
 Have you retained an attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name: _____	
Address: _____ _____	
Phone #: _____	

<b>3</b>	<b>ACCIDENT INFORMATION</b>
Date of Injury: _____ Time: _____ AM/PM State: <input type="checkbox"/> DC <input type="checkbox"/> MD <input type="checkbox"/> VA <input type="checkbox"/> Other _____	
Describe in DETAIL how your injury occurred: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	

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## PATIENT CONDITION

What are your present complaints? (location of pain, etc.)

Use an "X" on the drawing to mark where you are experiencing pain.

When did these symptoms first appear? \_\_\_\_\_

Does your pain interfere with:  Sleep  Daily routine  Work  Recreation

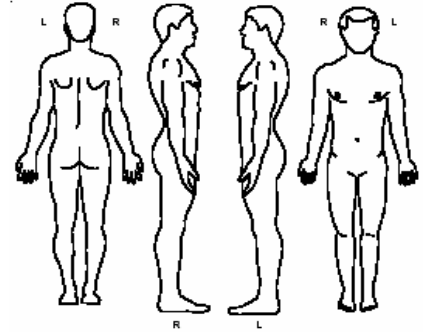
Are you working less hours/days as a result of your injuries?  Yes  No

If yes, please explain \_\_\_\_\_

Activities or movements that are painful to perform:

Sitting  Standing  Walking  Bending  Lying Down

Since the accident, are your symptoms:  Improving  About the same  Getting Worse



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## TREATMENT HISTORY

Have you been to the hospital for this condition?  Yes  No If yes, name of hospital? \_\_\_\_\_

When did you go? \_\_\_\_\_ How did you get there?  Ambulance  Self  Others

Were radiographs taken?  Yes  No If yes, what area(s)? \_\_\_\_\_

Were you prescribed any medication?  Yes  No If yes, what medications? \_\_\_\_\_

Have you seen any other doctor or received any other treatment for your current condition?  Yes  No

If yes, explain \_\_\_\_\_

Doctor's name and address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date(s) seen: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

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## HEALTH HISTORY

INJURIES/SURGERIES you may have had.	Description	Date (s)
Auto Accident (s)	_____	_____
Work Injuries	_____	_____
Broken Bones	_____	_____
Surgeries	_____	_____

**HAVE YOU EVER BEEN DIAGNOSED AS HAVING OR SUFFERING FROM: (place "X" in boxes that apply)**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Muscle disorder          | <input type="checkbox"/> Lungs, Asthma         | <input type="checkbox"/> Osteoarthritis           |
| <input type="checkbox"/> Nervous System Disorder  | <input type="checkbox"/> Broken Bones          | <input type="checkbox"/> Epilepsy                 |
| <input type="checkbox"/> Bone Disorder            | <input type="checkbox"/> Eating Disorder       | <input type="checkbox"/> Alcoholism               |
| <input type="checkbox"/> Rheumatoid Arthritis     | <input type="checkbox"/> Pace Maker            | <input type="checkbox"/> Drug Addiction           |
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Seizures/Convulsions` | <input type="checkbox"/> Strokes                  |
| <input type="checkbox"/> HIV                      | <input type="checkbox"/> A Congenital Disease  | <input type="checkbox"/> Cancer                   |
| <input type="checkbox"/> Gallbladder              | <input type="checkbox"/> Excessive Bleeding    | <input type="checkbox"/> Ulcer                    |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Hernias                  |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Ears, eyes, nose, throat |
| <input type="checkbox"/> Coughing Blood           | <input type="checkbox"/> Kidney, Bladder (GU)  | <input type="checkbox"/> Tumors                   |
| <input type="checkbox"/> Stomach, Intestines (GI) | <input type="checkbox"/> Circulatory Problems  | <input type="checkbox"/> Heart Disease            |

Female patients: Start date of most recent menstrual cycle: \_\_\_\_\_ Are you currently pregnant?  Yes  No

Doctor's name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**7****AUTHORIZATION FOR TREATMENT**

I hereby authorize the Doctor to treat my condition as he/she deems appropriate and to furnish any authorized requests for information regarding treatment. It is understood and agreed that the amount paid for the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while the patient is being treated at this office. The patient also agrees that he/she is responsible for all bills incurred at this office. (The Doctor will not be held responsible for any preexisting medically diagnosed conditions, nor for any medical diagnosis). The patient also agrees that statements made in this questionnaire are true and correct.

Patient's  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_