

# NEW PATIENT REGISTRATION FORM



Chittenden  
County  
Chiropractic

\* Please note: If this will be involving a Worker's Compensation Claim or an Auto Accident, please see the Office Manager before filling out this form.

NAME (LAST, FIRST, MIDDLE INIT.) \_\_\_\_\_

ADDRESS (STREET) \_\_\_\_\_

(CITY, STATE, ZIP) \_\_\_\_\_

PHONE HOME: \_\_\_\_\_ CELL \_\_\_\_\_

DATE OF BIRTH(MM/DD/YY) \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ EMAIL \_\_\_\_\_  
(optional) (optional)

WOULD YOU LIKE TO RECEIVE OUR MONTHLY NEWSLETTER BY E-MAIL? YES NO

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

EMPLOYER (COMPANY NAME) \_\_\_\_\_ OCCUPATION \_\_\_\_\_

ADDRESS \_\_\_\_\_  
(Street, City, State, Zip)

PHONE NUMBER \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_ SUBSCRIBER ID \_\_\_\_\_  
(policy holder's name)

GROUP NUMBER \_\_\_\_\_ RELATIONSHIP TO SUBSCRIBER \_\_\_\_\_  
(self, spouse, child, other)

IS THERE AN HEALTH SAVINGS ACCOUNT? YES NO

IS THERE A HIGH DEDUCTIBLE? YES NO IF YES, THE AMOUNT \_\_\_\_\_

IS THERE A SECONDARY INSURANCE? \_\_\_\_\_  
(List insurance company, ID #, group, etc.)

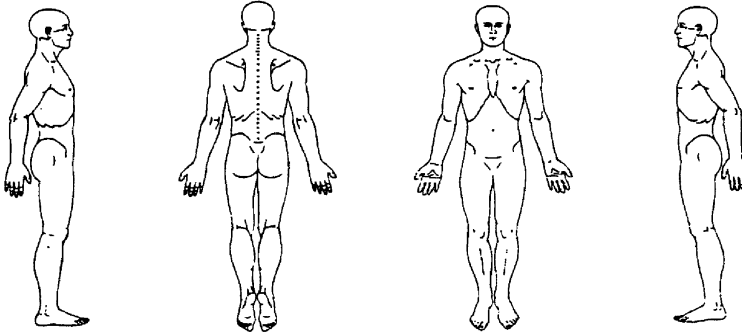
REASON FOR YOUR VISIT TODAY \_\_\_\_\_

WHEN DID YOUR SYMPTOMS FIRST APPEAR \_\_\_\_\_

(CONTINUED ON BACK)

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? YES NO UNKNOWN

MARK AN "X" ON THE PICTURE WHERE YOU HAVE PAIN, NUMBNESS, TINGLING



WHAT IS THE SEVERITY OF YOUR PAIN? (Little or no pain, moderate, severe) \_\_\_\_\_

WHAT TYPE OF PAIN IS IT? (Sharp, burning, shooting, etc.) \_\_\_\_\_

IS THE PAIN INTERMITTENT OR CONSTANT? \_\_\_\_\_

DOES THE PAIN INTERFERE WITH WORK, SLEEP, DAILY ROUTINE \_\_\_\_\_

\_\_\_\_\_

**HEALTH HISTORY**

HAVE YOU RECEIVED TREATMENT FOR YOUR CURRENT CONDITION? YES NO

IF YES, PLEASE LIST \_\_\_\_\_

ARE YOU TAKING ANY MEDICATIONS OR SUPPLEMENTS? YES NO

IF YES, PLEASE LIST \_\_\_\_\_

PLEASE LIST ANY FALLS, INJURIES, OR SURGERIES YOU HAVE \_\_\_\_\_

ARE YOU PREGNANT? YES NO DUE DATE \_\_\_\_\_

CIRCLE YOUR EXERCISE LEVEL: NONE MODERATE DAILY HEAVY

CIRCLE YOUR WORK ACTIVITY: SITTING STANDING LIGHT LABOR HEAVY LABOR

CIRCLE ANY HABITS YOU MAY HAVE: SMOKING ALCOHOL COFFEE/CAFFEINE HIGH STRESS

FREQUENCY: \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

HAVE YOU HAD ANY X-RAYS, MRI'S, CT-SCANS, OR OTHER TESTING DONE? YES NO

IF YES, PLEASE EXPLAIN \_\_\_\_\_

\_\_\_\_\_

PLEASE LIST ANY ILLNESSES, DISEASES, CONDITIONS, OR CONCERNS YOU HAVE HAD: \_\_\_\_\_

\_\_\_\_\_