Today's Date / / 20__ **CONFIDENTIAL PATIENT REGISTRATION**

Last name First MI

Date of birth / / Age ___Male ___Female ___Married ___Single ___Divorced

Street address

City State Zip

Phone Mobile Email

Employer/company Phone

Spouse's name Date of Birth / /

Spouse's employer

Emergency contact name Relationship Phone

Insurance company name Group number

Subscriber's name Birthdate / / ___check if same as above

Subscriber's relationship to patient

Do you have additional insurance? ___Yes ___No *If yes, complete the section below*

Secondary Insurance company name Group number

Subscriber's name Birthdate / / ___check if same as above

Subscriber's relationship to patient

I understand that I am financially responsible for all charges on the day of service whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. Dr. David J Schimp DC has permission to use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of submitting insurance claims (if insurance provides reimbursement for services the payment should come directly to you from your carrier).

Signature of patient, parent, guardian or personal representatitive_____

Print name_____Date _____ / _____ /_____ Relationship_____

What is the reason for your visit (you can mark the diagram)

Rate the severity of your pain (0=no pain, 10 = severe pain) 0 1 2 3 4 5 6 7 8 9 10

When did your symptoms begin? _____/_____/_____ ___Sudden ___Gradual

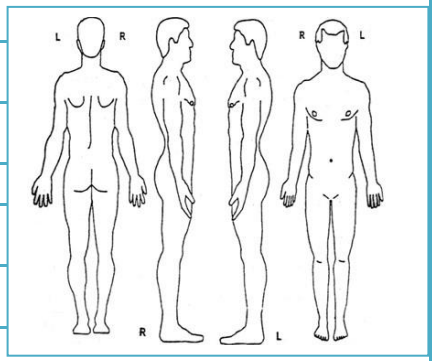
Do you know what caused your problem (please describe)? ___Lifting ___Twisting ___Bending ___Trauma ___Unknown

Describe your pain ___Sharp ___Dull ___Aching ___Shooting ___Focal ___Diffuse ___Throbbing ___Numbness ___Stiffness

___Burning ___Tingling ___Cramps ___Swelling Other:

Frequency ___Constant ___ 0-25% of the time ___25-50% of the time ___50-75% of the time ___75% plus

What aggravates your pain? ___Sitting ___Standing ___Bending ___Lifting ___Cough/Sneeze ___Twisting ___Reaching
Other:



Describe how your condition affects your daily life (i.e. what can't you do now because of your pain).

What relieves your symptoms? ___Heat ___Ice ___Rest ___Medication ___Activity
Other:

Have you had this condition before? ___Yes ___No

Have you been treated by another doctor for this condition (please describe)?

Do you have any other health concerns?

Prior treatments ___None ___Medications ___Surgery ___Physical Therapy ___Chiropractic

Name/s of other doctors (facility): Recent medical examinations, images, labs:

Associated Symptoms					
Fever, chills, night sweats	Yes	No	MEDICATIONS		
Loss of appetite	Yes	No	1.		
Weight loss	Yes	No	2.		
Nausea/vomiting	Yes	No	3.		
Double, blurred, dim vision	Yes	No	4.		
Dizziness, ringing in ears	Yes	No	5.		
Nose or throat problems	Yes	No	6.		
Heart palpitations	Yes	No	7.		
Shortness of breath	Yes	No	8.		
Constipation	Yes	No	ALLERGIES		
Diarrhea	Yes	No	1.		
Bloody stool or urine	Yes	No	2.		
Frequent urination	Yes	No	3.		
Burning with urination	Yes	No	4.		
Loss of bowel or bladder control	Yes	No	5.		
Loss of strength in arms or legs	Yes	No	SUPPLEMENTS		
Loss of sensation in arms or legs	Yes	No	1.		
Swelling in arms or legs	Yes	No	2.		
Current smoker	Yes	No	3.		
Past smoker >100 cigarettes	Yes	No	4.		
Coffee/caffeine use	Yes	No	5.		
High stress 1 2 3 4 5 6 7 8 9 10	Yes	No	FAMILY HISTORY		
Exercises daily	Yes	No	1.		
Work duties	Yes	No	2.		
Pregnant	Yes	No	3.		
Recent surgery	Yes	No	4.		

Health History											
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	Migraines	Yes	No	Scarlet fever	Yes	No
Anemia	Yes	No	Fractures	Yes	No	Miscarriage	Yes	No	Sexual transmitted disease	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 disorder	Yes	No
Asthma	Yes	No	Gout	Yes	No	Osteoporosis	Yes	No	Tonsillitis	Yes	No
Bleeding disorder	Yes	No	Heart disease	Yes	No	Pacemaker	Yes	No	Tuberculosis	Yes	No
Breast lump	Yes	No	Hepatitis	Yes	No	Parkinson's	Yes	No	Tumors, growth	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 infection	Yes	No
Cataracts	Yes	No	High blood pressure	Yes	No	Prostate problems	Yes	No	Whooping cough	Yes	No
Chemical dependency	Yes	No	High cholesterol	Yes	No	Prosthesis	Yes	No		Yes	No
Chicken pox	Yes	No	Kidney disease	Yes	No	Psychiatric care	Yes	No		Yes	No

Other