Brown Integrated Chiropractic

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Jason Brown, D.C.
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REGISTRATION & HISTORY

Date:_____

PATIENT INFORMATION

Name: _____ Nickname/Prefer to be called: _____

Address:_____City_____State_____Zip_____

Sex: ☐M ☐F Age:_____ Birth date___/___/_____ ☐single ☐married ☐widowed ☐separated ☐divorced ☐ partnered

Race: ☐American Indian ☐Asian ☐Black/African American ☐Hispanic ☐White ☐Other: _____ ☐ Decline to answer
Ethnicity:_____ ☐ Decline to answer

Language preference: ☐English ☐Spanish ☐Other

Patient Social Security Number _____-_____-_____

Occupation_____ Employer_____

Primary Care Provider: _____ Date of last visit:_____

Whom may we thank for referring you?_____

PHONE NUMBERS	EMERGENCY CONTACT
Home:	Name:
Work:	Relationship:
Cell:	Home:
Preferred contact: ☐ Home ☐ Work ☐ Cell	Work:
Email:	Cell:

INSURANCE INFORMATION

Do you plan to use health insurance for your care? ☐yes ☐no *(if yes, please complete the rest of this section)*
Insurance Company:_____
Relationship to insured: ☐ self ☐ spouse ☐ parent/guardian ☐ other

Assignment & Release:
I certify that I have insurance coverage and assign directly to Brown Integrated Chiropractic, PLLC all insurance benefits, if any, for Services rendered. I understand that I am responsible for understanding my insurance coverage and will be financially responsible for all charges whether or not paid by insurance. I authorize use of this signature on all insurance submissions.

SIGNATURE:

I understand that my healthcare information will be protected according to HIPAA and other state and federal regulations. I also understand I may request a more detailed description of these policies at any time.

I authorize Brown Integrated Chiropractic to discuss my healthcare with: □Primary Care Provider
Others as listed:_____

Patient Name:_____

INJURY/CONDITION

Will your visit today be for: ☐ Injury/ Health Condition / Pain ☐ Wellness/Sports Performance

Reason for Visit:

Was this injury related to an accident? ☐yes ☐no If yes, was it ☐ work-related ☐ auto ☐ other

When did it start? How did it start?

Please describe your condition:

Rate your symptoms (0=best, 10=worst) /10 With time is your condition? ☐getting better ☐getting worse ☐ not changing

Are your symptoms constant or do they come & go? ☐constant ☐ comes & goes

What makes your symptoms worse?

What makes your symptoms better?

What treatments have you already had for this condition: ☐none ☐medical ☐ chiropractic ☐ surgical ☐physical therapy ☐ massage ☐acupuncture ☐ other (please describe)

Have you had any recent imaging of the area? ☐ x-ray ☐ MRI ☐ CT scan ☐ bone density/DEXA ☐ other

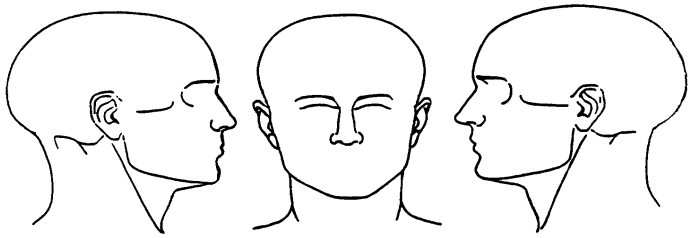
Does your condition interfere with your activities (work duties, daily life, social activities, and/or recreation)? ☐yes ☐no

If yes, please list 3 activities that you have difficulty with:

1._____
2._____
3._____

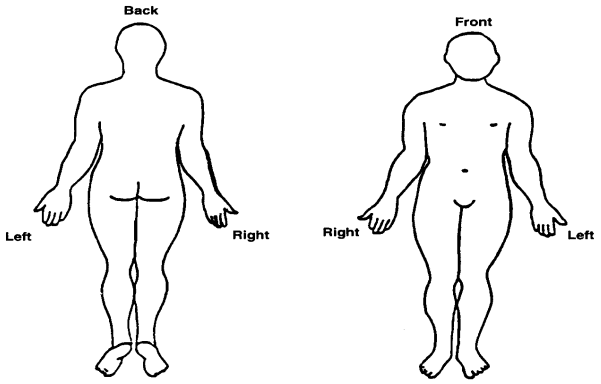
Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
^ ^ ^ ^ ^ ^	= = = = = =	o o o o o o	. . . . .	/ / / / / / /	x x x x x
^ ^ ^ ^	= = = = = =	o o o o	. . . . .	/ / / /	x x x

Please draw your symptoms



No Pain ——— Worst Pain Possible

Please make a slash through this line as to the level of your pain.



No Pain ——— Worst Pain Possible

Please make a slash through this line as to the level of your pain.

HEALTH HISTORY					
Have you had any of the following:		High Blood Pressure	☐yes ☐no	WOMEN ONLY:	
AIDS/HIV	☐yes ☐no	High cholesterol	☐yes ☐no	Are you pregnant?	☐yes ☐no
Anemia	☐yes ☐no	Multiple Sclerosis	☐yes ☐no	Due date:	
Anxiety	☐yes ☐no	Osteopenia	☐yes ☐no	Abnormal/painful menstrual cycle	☐yes ☐no
Arthritis	☐yes ☐no	Osteoporosis	☐yes ☐no		
Asthma	☐yes ☐no	Pacemaker	☐yes ☐no	Miscarriage	☐yes ☐no
Bleeding disorders	☐yes ☐no	Parkinson's disease	☐yes ☐no	Menopause	☐yes ☐no
Cancer	☐yes ☐no	Pinched nerve	☐yes ☐no	PRIOR SURGERIES	Date
Chemical dependency	☐yes ☐no	Polio	☐yes ☐no		
Depression	☐yes ☐no	Prostate problem	☐yes ☐no		
Diabetes	☐yes ☐no	Prosthesis	☐yes ☐no		
Epilepsy/Seizures	☐yes ☐no	Psychiatric care	☐yes ☐no		
Fractures	☐yes ☐no	Rheumatoid arthritis	☐yes ☐no		
Headaches	☐yes ☐no	Stroke	☐yes ☐no		
Heart disease	☐yes ☐no	Suicide attempt	☐yes ☐no		
Hepatitis	☐yes ☐no	Thyroid problems	☐yes ☐no		
Hernia	☐yes ☐no	Tumors	☐yes ☐no		
Herniated disk	☐yes ☐no	Ulcers	☐yes ☐no		

Additional Info:

_____

_____

_____

_____

Please list your current:

Height: _____ft _____in Weight: _____lbs

MEDICATIONS	ALLERGIES	VITAMINS/SUPPLEMENTS

FAMILY HISTORY *(Does anyone in your family have any of the following?)*			
☐ Arthritis-Rheumatism	☐ Diabetes	☐ Osteoporosis/Osteopenia	OTHER: *(Please list)*
☐ Autoimmune disorders	☐ Heart Disease	☐ Stroke	
☐ Back/Spine Condition	☐ High blood pressure	☐ Thyroid disorder	
☐ Cancer	☐ Mental Illness		

SOCIAL HISTORY
My work duties include: ☐ standing ☐ sitting ☐ light labor ☐ heavy labor ☐ other
My exercise level is: ☐ Intense ☐Moderate ☐ Light ☐ Minimal ☐ None
My current exercise includes: *(list activities)*
Alcohol consumption drinks per week Caffeine consumption: cups/day Recreational drug use ☐
Are you currently a smoker? ☐Yes ☐No If yes, do you smoke every day? ☐Yes ☐No
Did you smoke previously? ☐Yes ☐No

Patient Signature _____ **Date** _____