PIAZZA & PIAZZA
FAMILY CHIROPRACTIC

CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date ______ SS/HIC/Patient ID # ______

Patient Name ______ ______ ______
Last Name First Name Middle Initial

Address ______

Email ______ City ______ State ______ ZIP ______

Sex Male ☐ Female ☐ Birth Date ______

☐ Married ☐ Windowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for_________Years

Patient Employer/School ______ Occupation ______

Employer/School Address ______

Whom may we thank for referring you? ______

2 INSURANCE INFORMATION

Who is responsible for this account? ______ Relationship to Patient ______

Insurance Co. ______ Group # ______

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. ______ all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. 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 to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______
Signature of Patient, Parent, Guardian or Personal Representative

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

______ ______
Date Relationship to Patient

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3 PHONE NUMBERS

Cell Phone ____ Home Phone ____

Best time and place to reach you ____

IN CASE OF EMERGENCY, CONTACT

Name ____ Relationship ____

Home Phone ____ Work Phone ____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date ____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

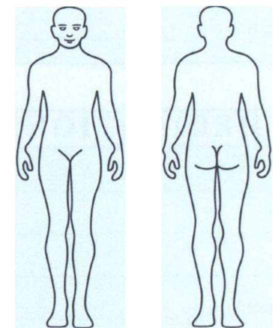
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (If applicable) ____

5 PATIENT CONDITION

Reason for Visit ____

When did your symptoms appear? ____



Is this condition 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 1 O (severe pain) ____

Type of Pain

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching

☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? ____

Is it constant or does it come and go? ____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

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What treatment you already have received for your condition?

- [ ] Medications
- [ ] Surgery
- [ ] Physical Therapy
- [ ] Chiropractic Services
- [ ] None
- [ ] Other

Date of Last: Physical Exam

Spinal Exam

Chest X-Ray

Dental X-Ray

MRI, CT-Scan, Bone Scan

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

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDs/HIV	Yes	No	Diabetes	Yes	No	Liver Disease	Yes	No
Alcoholism	Yes	No	Emphysema	Yes	No	Rheumatic Fever	Yes	No
Allergy Shots	Yes	No	Epilepsy	Yes	No	Measles	Yes	No
Anemia	Yes	No	Fractures	Yes	No	Migraine Headaches	Yes	No
Appendicitis	Yes	No	Goiter	Yes	No	Multiple Sclerosis	Yes	No
Arthritis	Yes	No	Gout	Yes	No	Osteoporosis	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Thyroid Problems	Yes	No
Bleeding Disorders	Yes	No	Hepatitis	Yes	No	Pacemaker	Yes	No
Bronchitis	Yes	No	Hernia	Yes	No	Parkinson's Disease	Yes	No
Bulimia	Yes	No	Herniated Disk	Yes	No	Tumors, Growths	Yes	No
Cancer	Yes	No	Pneumonia	Yes	No	Pinched Nerve	Yes	No
Chemical Dependency	Yes	No	High Blood Pressure	Yes	No	Prostate Problem	Yes	No
Chicken Pox	Yes	No	High Cholesterol	Yes	No	Psychiatric Care	Yes	No
Kidney Disease	Yes	No	Rheumatoid Arthritis	Yes	No	Prosthesis	Yes	No

- [ ] Stroke
- [ ] Other

Exercise	**Work Activity**	**Habits**	
None	Sitting	Smoking	Packs/Day
Moderate	Standing	Alcohol	Drinks/Week
Daily	Light Labor	Coffee/Caffeine Drinks	Cups/Day
Heavy	Heavy Labor	High Stress Level	Reason

Are you Pregnant? ☐ Yes ☐ No Due Date

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

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MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

Pharmacy Name

Pharmacy Phone