Bryenton Family Chiropractic

12575 Newport Ave, C. Tustin, CA 92780

Registration and History

Patient Information

Date _____

Patient ID # _____

Patient Name_____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State_____ Zip_____

E-mail _____

Sex: □ M □ F Age_____

Birth Date _____

□ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered for _____years

Occupation_____

Patient Employer/School_____

Employer/School Address_____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Spouse's Birth Date _____

Spouse's Employer_____

Whom may we thank for referring you? _____

Phone Numbers

Home Phone (_____)_____Alt. Phone(_____)_____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name_____Relationship_____

Home Phone (_____)_____Alt. Phone(_____)_____

Insurance

Who is responsible for this account?_____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? □ Yes □ No

Subscriber's Name _____

Birth Date _____ SS#_____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependant(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 services 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

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)_____

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 to the right where you continue to have pain, numbness or tingling ▶

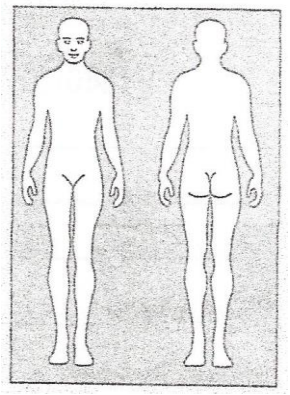
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

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



Health History

What treatment have you already received for your condition? □ Medications □ Surgery □ Physical Therapy

□ Chiropractic Services □ None □ Other_____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Mark box "Yes" or "No" to indicate if you have had any of the following:

AID/HIV	□ Yes	□ No	Emphysema	□ Yes	□ No	Migraine Headaches	□ Yes	□ No	Sexually Transmitted Disease	□ Yes	□ No
Alcoholism	□ Yes	□ No	Epilepsy	□ Yes	□ No	Miscarriage	□ Yes	□ No			
Allergy Shots	□ Yes	□ No	Fractures	□ Yes	□ No	Mononucleosis	□ Yes	□ No	Stroke	□ Yes	□ No
Anemia	□ Yes	□ No	Glaucoma	□ Yes	□ No	Multiple Sclerosis	□ Yes	□ No	Suicide Attempt	□ Yes	□ No
Anorexia	□ Yes	□ No	Goiter	□ Yes	□ No	Mumps	□ Yes	□ No	Thyroid Problems	□ Yes	□ No
Appendicitis	□ Yes	□ No	Gonorrhea	□ Yes	□ No	Osteoporosis	□ Yes	□ No	Tonsillitis	□ Yes	□ No
Arthritis	□ Yes	□ No	Gout	□ Yes	□ No	Pacemaker	□ Yes	□ No	Tuberculosis	□ Yes	□ No
Asthma	□ Yes	□ No	Heart Disease	□ Yes	□ No	Parkinson's Disease	□ Yes	□ No	Tumors, Growths	□ Yes	□ No
Bleeding Disorders	□ Yes	□ No	Hepatitis	□ Yes	□ No	Pinched Nerve	□ Yes	□ No	Typhoid Fever	□ Yes	□ No
Breast Lump	□ Yes	□ No	Hernia	□ Yes	□ No	Pneumonia	□ Yes	□ No	Ulcers	□ Yes	□ No
Bronchitis	□ Yes	□ No	Herniated Disk	□ Yes	□ No	Polio	□ Yes	□ No	Vaginal Infections	□ Yes	□ No
Bulimia	□ Yes	□ No	Herpes	□ Yes	□ No	Prostate Problem	□ Yes	□ No	Whooping Cough	□ Yes	□ No
Cancer	□ Yes	□ No	High Blood Pressure	□ Yes	□ No	Prosthesis	□ Yes	□ No	Other _____		
Cataracts	□ Yes	□ No	High Cholesterol	□ Yes	□ No	Psychiatric Care	□ Yes	□ No	_____		
Chemical Dependency	□ Yes	□ No	Kidney Disease	□ Yes	□ No	Rheumatoid Arthritis	□ Yes	□ No	_____		
Chicken Pox	□ Yes	□ No	Liver Disease	□ Yes	□ No	Rheumatic Fever	□ Yes	□ No	_____		
Diabetes	□ Yes	□ No	Measles	□ Yes	□ No	Scarlet Fever	□ Yes	□ No	_____		

Please mark in each column which boxes best describe your activities:

EXERCISE
□ None
□ Moderate
□ Daily
□ Heavy

WORK ACTIVITY
□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

HABITS
□ Smoking Packs/Day_____
□ Alcohol Drinks/Week_____
□ Coffee/Caffeine Drinks Cups/Day_____
□ 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		

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (_____) _____	_____	_____
Pharmacy E-mail _____	_____	_____

Signature of person completing this form _____ Date_____