

# REGISTRATION INFORMATION

## PATIENT INFORMATION

First Name: \_\_\_\_\_ MI: \_\_\_ Last Name: \_\_\_\_\_ SS #: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_  
Sex: \_\_\_ M \_\_\_ F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Separated  
Employer Name and Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell: \_\_\_\_\_ Email: \_\_\_\_\_  
Emergency Contact Name and Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Who referred you to our office? \_\_\_\_\_

## INSURED INFORMATION

If you are the insured party, mark "self" and move down to the "Insurance Information".

Patient's relationship to the insured: \_\_\_ Self \_\_\_ Spouse \_\_\_ Dependent

First Name: \_\_\_\_\_ MI: \_\_\_ Last Name: \_\_\_\_\_ SS #: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_  
Sex: \_\_\_ M \_\_\_ F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Separated  
Employer Name and Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell: \_\_\_\_\_ Email: \_\_\_\_\_  
Occupation: \_\_\_\_\_

## INSURANCE INFORMATION

**Insurance Company:** \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Claims Address: \_\_\_\_\_  
ID Number: \_\_\_\_\_ Group or Policy Number: \_\_\_\_\_  
**Secondary Insurance:** \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Claims Address: \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I hereby assign, transfer and set over to Laux Chiropractic and Jonathan Laux, D.C. all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I revoke said authorization by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Do we have your permission to communicate with your primary care physician about your case?

Y N

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## What Brings You To Our Office?

First complaint: \_\_\_\_\_

When did the problem start? \_\_\_\_\_ ( ) Sudden ( ) Gradual ( ) Progressive How? \_\_\_\_\_

What increases your pain? \_\_\_\_\_

What decreases your pain? \_\_\_\_\_

How would you describe the pain? (Please circle) Dull Sharp Burning Numb/Tingling Throbbing

Other: \_\_\_\_\_

Does the pain travel or radiate to any other parts of your body? \_\_\_\_\_

How severe is the symptom (0=No Pain, 10=Unbearable Pain) 0 1 2 3 4 5 6 7 8 9 10

How % of your day do you notice the symptom? 10% 25% 50% 75% 100%

Is it : (Please circle) Getting Better Staying the same Getting Worse

Have you ever experienced this problem before? Y N When? \_\_\_\_\_

Second complaint: \_\_\_\_\_

When did the problem start? \_\_\_\_\_ ( ) Sudden ( ) Gradual ( ) Progressive How? \_\_\_\_\_

What increases your pain? \_\_\_\_\_

What decreases your pain? \_\_\_\_\_

How would you describe the pain? (Please circle) Dull Sharp Burning Numb/Tingling Throbbing

Other: \_\_\_\_\_

Does the pain travel or radiate to any other parts of your body? \_\_\_\_\_

How severe is the symptom (0=No Pain, 10=Unbearable Pain) 0 1 2 3 4 5 6 7 8 9 10

How % of your day do you notice the symptom? 10% 25% 50% 75% 100%

Is it : (Please circle) Getting Better Staying the same Getting Worse

Have you ever experienced this problem before? Y N When? \_\_\_\_\_

List any other complaints currently bothering you and rate your pain level for each.

A. \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

B. \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

C. \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

Since your symptoms began, have you noticed any changes in:

Bowel Function Y N

Bladder Function Y N

Ability to maintain an erection Y N

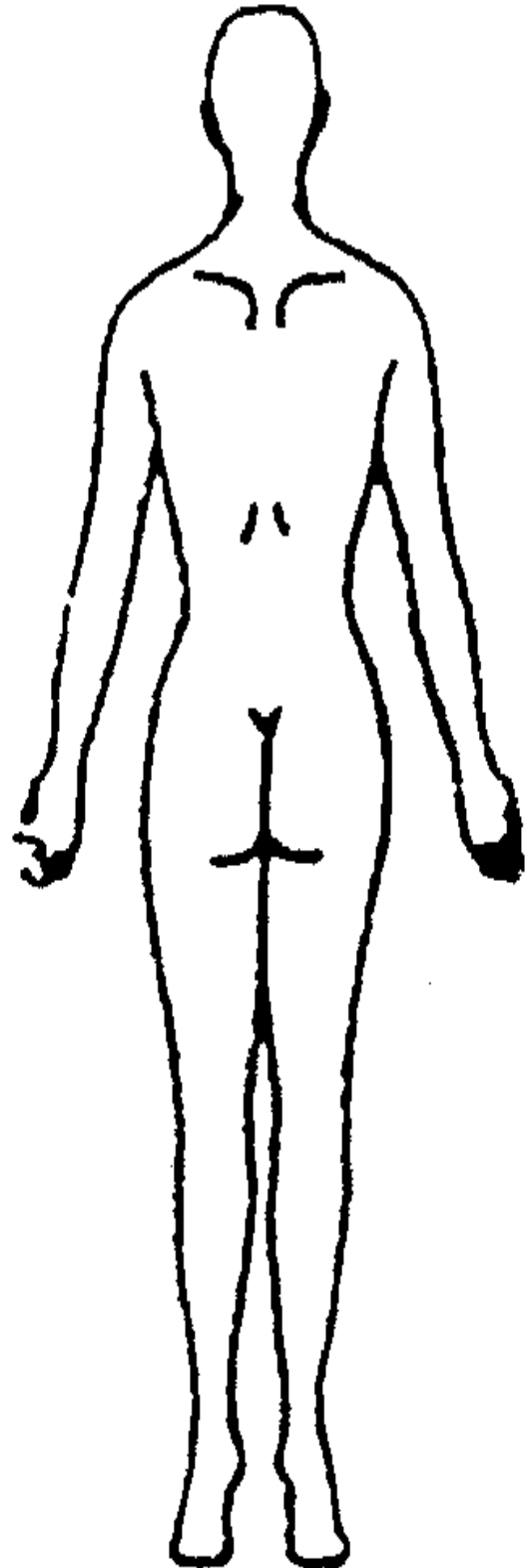
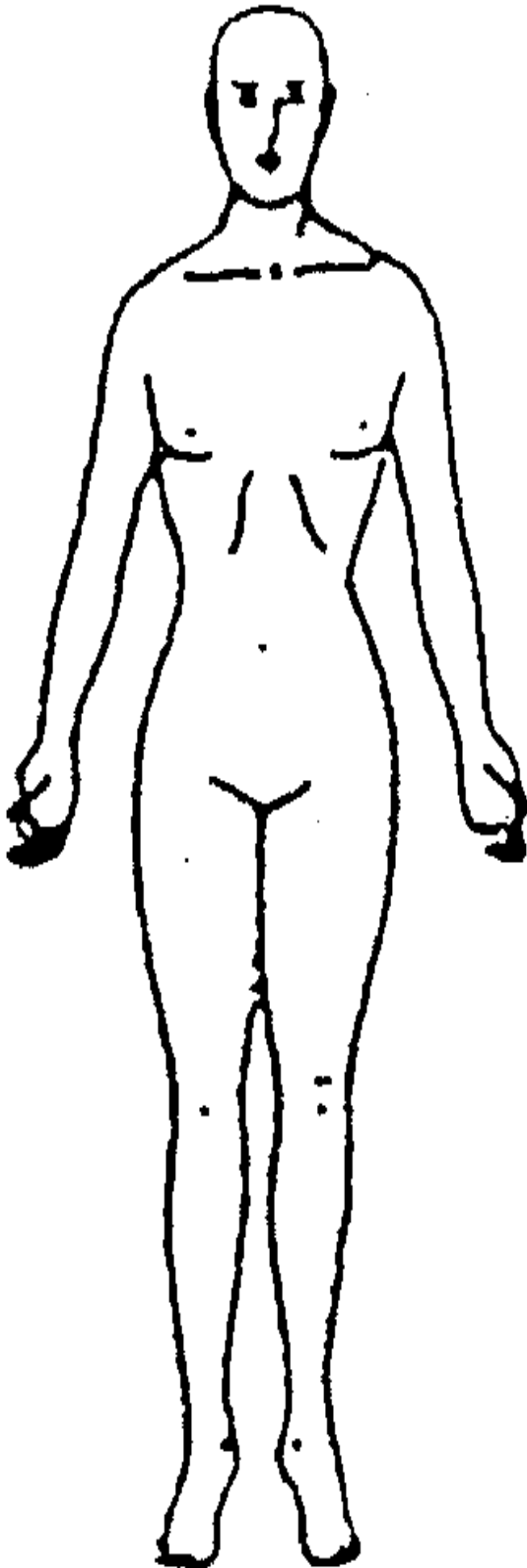
Please list all previous treatments for this condition:

Doctor's Name	Date	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please mark the area(s) on your body where you feel symptoms with the following symbols on the "Pain Diagram" below:

**P** = Pain   **N** = Numbness   **S** = Stiffness   **T** = Tingling   **B** = Burning



Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Past Health History

Please indicate if you **NOW HAVE** or have **HAD IN THE PAST** any of the following illnesses:

Write "N" for now and "P" for past.

- |                                               |                                          |                                                        |                                             |                                              |
|-----------------------------------------------|------------------------------------------|--------------------------------------------------------|---------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Stroke          | <input type="checkbox"/> Aneurysm(s)                   | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Heart Trouble       |
| <input type="checkbox"/> HIV                  | <input type="checkbox"/> AIDS/ARC        | <input type="checkbox"/> Sinus Trouble                 | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Anemia              |
| <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Allergies       | <input type="checkbox"/> Polio                         | <input type="checkbox"/> STD's              | <input type="checkbox"/> Asthma              |
| <input type="checkbox"/> Low Blood Pressure   | <input type="checkbox"/> Broken Bones    | <input type="checkbox"/> Emphysema                     | <input type="checkbox"/> Ulcer              | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Liver Trouble   | <input type="checkbox"/> Scoliosis                     | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Prostate Trouble    |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Pacemaker       | <input type="checkbox"/> Hay Fever                     | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Dislocated Joints   |
| <input type="checkbox"/> Kidney Trouble       | <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Mental/Emotional Difficulties |                                             |                                              |

Have you been to a chiropractor before? **Y N**

Name and address: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_

Name and address: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_

Do you have a family physician? **Y N**

Name and address: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_

Please list dates and reasons for all hospitalizations: \_\_\_\_\_

Please list all surgeries and dates: \_\_\_\_\_

Please list all accidents/injuries: List dates and describe injuries:

Auto: \_\_\_\_\_

Work: \_\_\_\_\_

Sports/Recreational: \_\_\_\_\_

Home: \_\_\_\_\_

Childhood: \_\_\_\_\_

Are you currently taking any vitamins, minerals, herbs or supplements? **Y N**

Please list: \_\_\_\_\_

Are you taking any medications? **Y N**

Name of Drug	For What?	Name of Drug	For What?
_____	_____	_____	_____
_____	_____	_____	_____

For **WOMEN** only: To your knowledge, **ARE YOU PREGNANT?** **Y N**

If pregnant in past, were pregnancies normal? **Y N** If no, explain: \_\_\_\_\_

Do you see an OB-GYN regularly? **Y N** Date of last exam? \_\_\_\_\_

### Family History

Age(s)	Health Problems or cause of death
Mother: _____	_____
Father: _____	_____
Brothers: _____	_____
Sisters: _____	_____
Children: _____	_____

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Review of Systems**  
**Please check off all current symptoms**

**General**

- General Fatigue
- Weakness
- Fever (Continuous)
- Loss of Sleep
- Chills (Continuous)
- Unplanned Weight Change
- Night Sweats

**Mouth**

- Mouth Sores
- Bleeding Gums
- Enlarged Glands
- Absence of Taste
- Abnormal Taste Sensations
- Tonsillitis/Infected Tonsils
- Difficulty in Swallowing

**Skin**

- Skin Rash
- Redness of Skin
- Skin Itching
- Skin Dryness
- Eczema
- Hair Changes

**Heart/Lungs**

- Chronic Cough
- Wheezing (Chronic)
- Difficulty Breathing
- Swollen Extremities
- Blue Extremities
- Varicose Veins
- Rapid Heart Beat
- Chest Pain
- Heart Palpitations
- Heart Murmur

**Nose**

- Sinus Pain
- Excessive Drainage
- Nose Bleeds (Chronic)
- Nasal Infections (Chronic)
- Absence of Smell

**Breasts**

- Lumps In Breast(s)
- Redness/Itching of Breast
- Dimpling of Breast
- Discharge from Breast
- Breast Pain

**Reproductive/Urinary**

- Painful Urination
- Inability to Hold Urine
- Frequent Urination
- Bed-wetting
- Irregular Menstration
- Abnormal Vaginal Bleeding
- Sterility
- Impotence/Erectile Dysfunction

**Neurological**

- Headaches
- Dizziness
- Fainting
- Convulsions
- Nervousness
- Numbness

**Mental**

- Anxiety
- Depression
- Phobias
- Memory Loss
- Mood Swings

**Stomach/Intestines**

- Decreased Appetite
- Increased Appetite
- Abdominal Pain
- Hemorrhoids
- Excess Gas
- Vomiting (Excessive)
- Diarrhea (Excessive)
- Constipation
- Heartburn/Indigestion

**Ears**

**L R**

- Hearing Trouble
- Ringing in Ears
- Pain in Ears
- Ear Discharge

**Eyes**

**L R**

- Vision Trouble
- Pain in Eyes
- Eye Discharge

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Doctor's Notes**