

# 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

**The Other Party's Insurance Company:** \_\_\_\_\_

Claims Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Claim Number: \_\_\_\_\_

**Your Auto Insurance Company:** \_\_\_\_\_

Claims Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Claim Number: \_\_\_\_\_

**Your Health Insurance Company:** \_\_\_\_\_

ID Number: \_\_\_\_\_ Group or Policy Number: \_\_\_\_\_

## 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

## Auto Accident Information:

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

1. Date of Crash: \_\_\_\_\_ Time of Day: \_\_\_\_\_ Road Condition  Dry  Wet
2. Was the crash on the job?  Yes  No
3. Were you:  Driver  Passenger  Front Seat  Back Seat  Motorcycle
4. If you weren't the driver, who was the vehicle driven by? \_\_\_\_\_
5. Number of people in your vehicle? \_\_\_\_\_
6. Your estimated speed at crash: \_\_\_\_\_ MPH
7. Make/model of your car: \_\_\_\_\_ Make/model of *other* vehicle: \_\_\_\_\_
8. Head Restraints in your vehicle:  None  Adjustable type  Up  Down  Don't know  
If head restraint is adjustable, was position changed by the crash?  Yes  No
9. Was the seat back changed by the crash?  Yes  No
10. Was the seat back broken?  Yes  No
11. Were you wearing a seat belt?  Y  N If no, go to question #12  
If yes, were you wearing a lap belt?  Yes  No Shoulder harness?  Yes  No
12. If your vehicle was equipped with air bags, did they activate?  Yes  NO  
If yes, were you struck by the airbag?  Yes  No
13. Were you struck from:  Behind  Front  Left Side  Right Side  
Other combination, please describe: \_\_\_\_\_
14. What was the position of your head during the crash?  
 Straight Ahead  Turned Right  Turned Left  Other \_\_\_\_\_
15. Your body position at impact?  Good  Forward lean  Other \_\_\_\_\_
16. If driving, hands on the wheel?  One  Two
17. Were the brakes applied?  Yes  No
18. Were you aware of impending crash?  Yes  No
19. In your own words, please describe the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
20. Did any part of your body strike/hit anything inside of your vehicle (steering wheel, dashboard, etc)?  
 Y  N If yes, please explain \_\_\_\_\_  
\_\_\_\_\_
21. Did your vehicle strike any objects after the crash?  Yes  No  
If yes, please describe: \_\_\_\_\_
22. Were you wearing a hat or glasses?  Yes  No If yes, still on after crash?  Yes  No
23. Did any items become displaced in the vehicle (rearview mirror, ashtray, packages, etc.)?  
 Y  N If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
24. Did you lose consciousness during the crash?  Y  N If yes, for how long? \_\_\_\_\_
25. Estimated property damage to your vehicle? \$ \_\_\_\_\_
26. Estimated damage to other vehicle?  None  Mild  Moderate  Severe

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

27. Were the police notified? [ ] Y [ ] N Was a report made? \_\_\_Yes \_\_\_No

**\*\*\*Please provide this office with a copy of the police report.\*\*\***

28. What direction were you headed? [ ] North [ ] South [ ] East [ ] West

(If you are not sure, leave direction questions blank)

On (name of street and city): \_\_\_\_\_

29. What direction was the other vehicle headed? [ ] North [ ] South [ ] East [ ] West

On (name of street and city): \_\_\_\_\_

### After the Crash

30. Immediately after the crash, what symptoms did you have? \_\_\_Headache \_\_\_Dizziness \_\_\_Neck Pain

\_\_\_ Nausea \_\_\_Confusion/Disorientation \_\_\_Back Pain \_\_\_Numbness/Tingling

\_\_\_ Extremity Pain: \_\_\_\_\_

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

31. If you developed other symptoms, what were they and how long did they take to appear?

\_\_\_\_\_

\_\_\_\_\_

32. Where did you go after the crash? \_\_\_Hospital \_\_\_Home \_\_\_Work

33. How did you get there? \_\_\_\_\_

### Emergency Department

34. If you went to the hospital, when did you go? \_\_\_ Immediately \_\_\_Hours later \_\_\_Days later

35. Did they take x-rays? \_\_\_Yes \_\_\_No

If yes, which body parts were x-rayed? \_\_\_\_\_

What were the results of those x-rays? \_\_\_\_\_

36. Was blood work done? \_\_\_Yes \_\_\_No

37. Did they give you? \_\_\_Cervical Collar \_\_\_Medications \_\_\_Ice \_\_\_Other: \_\_\_\_\_

38. What were the follow up instructions? \_\_\_\_\_

### General Questions

39. Did you have any physical complaints BEFORE the accident? [ ] Y [ ] N

If yes, please describe in detail: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

40. Have you been treated by another doctor since this accident? [ ] Y [ ] N

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

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

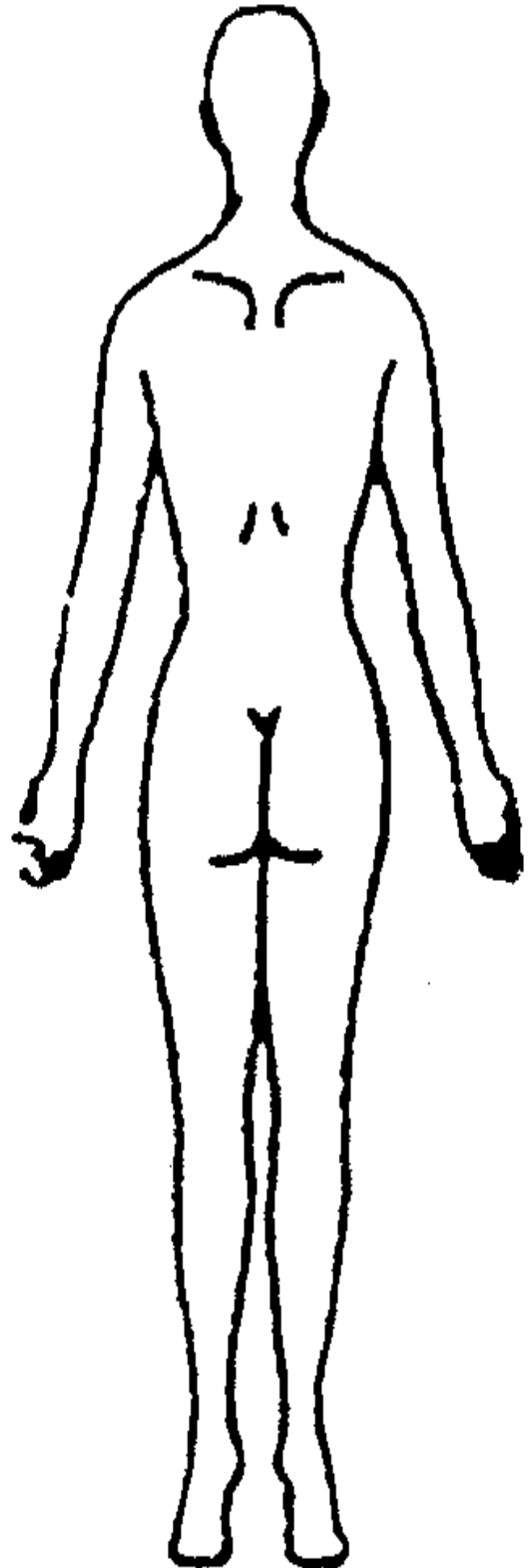
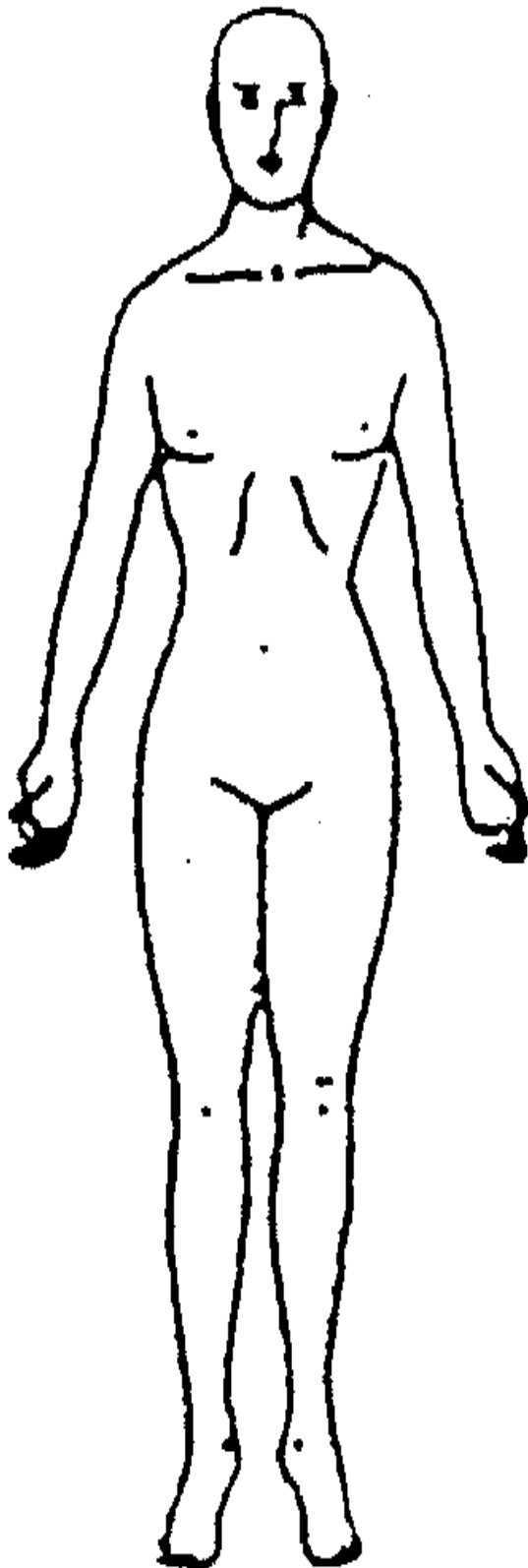
Please list all previous treatments for this condition:

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**