

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
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

***** If You Have Received Your BWC Card, Make Sure We Get A Copy Of It *****

Name Managed Care Organization _____
BWC Claim 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

Name: _____ Date: _____

Work Accident History

Employer Information

Company Name _____ Supervisor Name _____ Work Phone # _____

Address _____ City _____ State _____ Zip _____

Nature of business (eg., food manufacturing, building construction, retailer of women's clothes) _____

Accident/Injury History

1. Date of accident/injury: _____ [] Gradual [] Sudden [] Progressive

2. Address/City/State/Zip where you were injured: _____

3. Time of day when accident occurred: _____ am/pm Date last worked: _____

4. Did you report this to your employer? [] Y [] N If so, to whom? _____

5. Did you go to the hospital or another doctor's office after the accident? [] Y [] N

If so, where: _____

Were X-rays taken? [] Y [] N

What type of treatment was administered? _____

Was a diagnosis made? [] Y [] N If so, what was it? _____

6. Describe how the accident/injury happened: _____

7. Do you feel you could perform your usual job right now? [] Y [] N

8. Describe your routine job duties:

9. If you are working, how has your current condition affected your normal duties?

10. Is there any activity or duty you are unable to perform? _____

11. How often does your job require you to do the following:

_____ Lifting (_____ lbs)

- ____ Sitting (____ hrs/day)
- ____ Standing (____ hrs/day)
- ____ Computer (____ hrs/day)
- ____ Telephone (____ hrs/day)
- ____ Driving (____ hrs/day)
- ____ Push/pull (__ Once in a while __ Often __ Frequently __ Almost all the time)
- ____ Reach overhead (__ Once in a while __ Often __ Frequently __ Almost all the time)
- ____ Grasping (__ Once in a while __ Often __ Frequently __ Almost all the time)
- ____ Twisting/bending (__ Once in a while __ Often __ Frequently __ Almost all the time)
- ____ Squatting/kneeling (__ Once in a while __ Often __ Frequently __ Almost all the time)
- ____ Walking (__ Once in a while __ Often __ Frequently __ Almost all the time)
- ____ Climbing/ladders (__ Once in a while __ Often __ Frequently __ Almost all the time)
- ____ Other Please explain: _____

12. Have you ever been injured at work prior to this accident/injury? [] Y [] N

When? _____ Please explain: _____

13. Have you ever been involved in an automobile accident before? [] Y [] N

When? _____ Were you injured? [] Y [] N

Please explain: _____

24. Please add anything else you would like the doctor to know:

Please continue to the next page...

Doctor's Notes

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

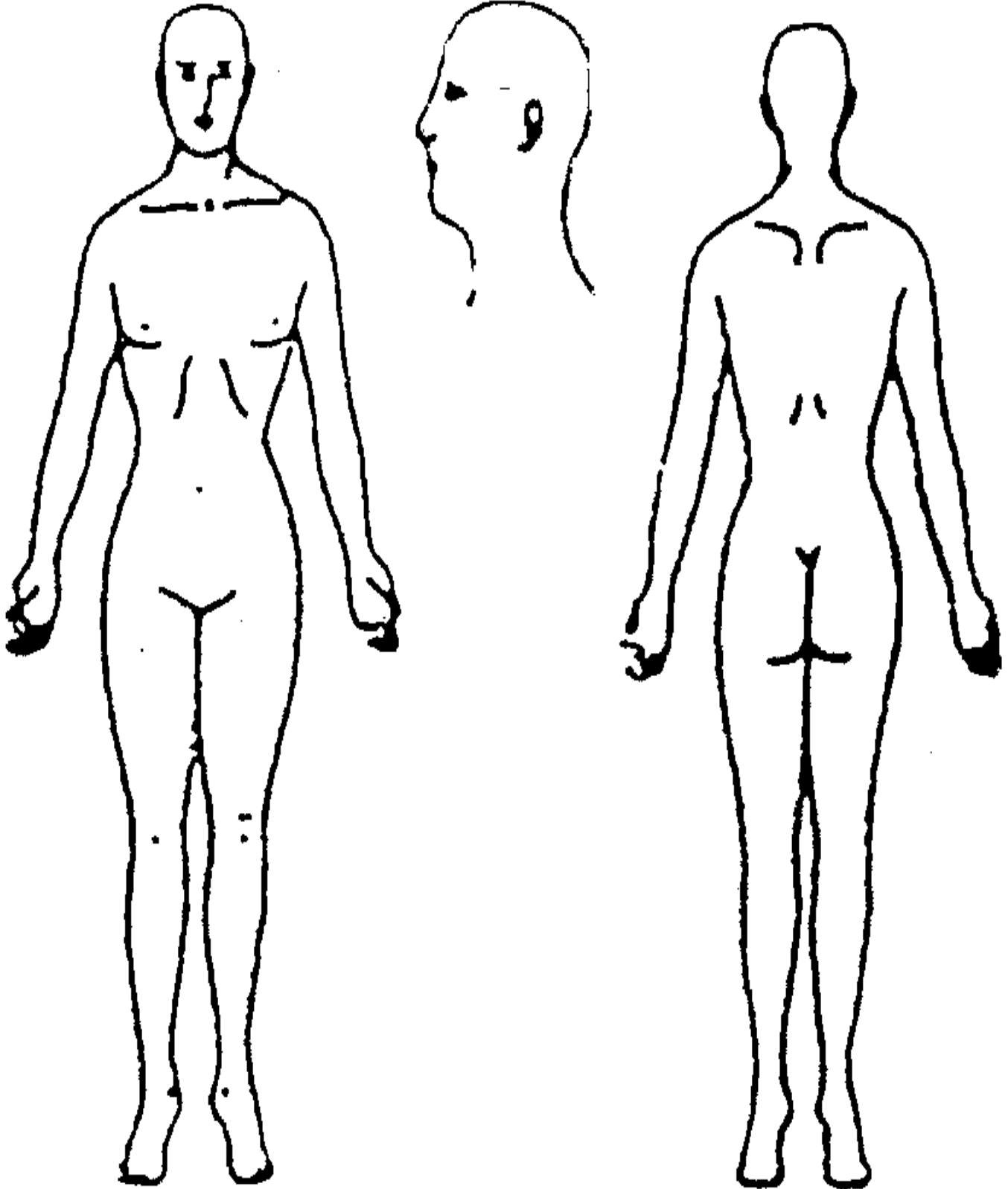
Please list all previous treatments for this condition:

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 |
| <input type="checkbox"/> Hearing Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Pain in Ears | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Ear Discharge | <input type="checkbox"/> | <input type="checkbox"/> |

Eyes

- | | | |
|---|--------------------------|--------------------------|
| | L | R |
| <input type="checkbox"/> Vision Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Pain in Eyes | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Eye Discharge | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Signature: _____ Date: _____

Doctor's Notes