

# Welcome

## Registration Form

### PATIENT INFORMATION

Last Name, First Name MI		Title		Preferred Name	
Date of Birth	Age	Gender	Marital Status	Spouse/Parent Name	
Street Address			City	State	Zip
Mailing Address (if different)			City	State	Zip
SSN	Home Number	Cell Number	Work Number		
Email (for private use by this office only)			Employer	Occupation	
Whom may we thank for referring us to you?			Other family members seen here		

### EMERGENCY CONTACT

Name of local friend or relative (not living with you)	Home Phone	Cell Phone
--	------------	------------

### INSURANCE INFORMATION

Person responsible for bill	Is this person a patient here?		
Primary subscriber name	Date of birth		
Primary Insurance	Phone	ID/SSN # of subscriber	Group #
Secondary subscriber name	Date of birth		
Secondary Insurance	Phone	ID/SSN of subscriber	Group #

**B A C K A N D B O D Y**  
**CHIROPRACTIC**

# HEALTH HISTORY QUESTIONNAIRE

## SYMPTONS

Reason for visit: \_\_\_\_\_

When did you first notice the symptoms? \_\_\_\_\_

Is the condition getting progressively worse? \_\_\_\_\_

Where specifically is the problem(s) located? \_\_\_\_\_

What activities are difficult to perform?  Sitting  Standing  Walking  Bending  Lying

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

Type of Pains:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting

Burning  Tingling  Cramps  Stiffness  Swelling

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

Rate the severity of your pain (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? \_\_\_\_\_

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

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

Name of other doctors(s) who have treated you for your condition: \_\_\_\_\_

## CONDITIONS

Check if you have, or had, any conditions/symptoms in the following areas to a significant degree

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV           | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herniated Disc     | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Depression          | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Tumor, Growths     |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Polio                | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Prostrate Problems   | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Measles            | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Migraine Headache  | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Other: _____       |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Gout                | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever        |   |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Stroke               |   |

List all medications you are currently taking: \_\_\_\_\_

Allergies: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Is there anything else we should know about you heath history?  yes  no If yes, please explain: \_\_\_\_\_

## DAILY HABITS

What type of exercise do you perform on a daily basis?  None  Light  Moderate  Heavy

What kind of vitamins do you take? \_\_\_\_\_

What kind of nutritional supplements do you take (if any)? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much per day? \_\_\_\_\_

How much liquor do you consume on a weekly basis? \_\_\_\_\_

How much coffee or caffeinated beverages do you consume on a daily basis? \_\_\_\_\_

## CONSENT TO TREAT A MINOR

(If applicable)

Back & Body Chiropractic has my permission to render any medically necessary services to my child

\_\_\_\_\_  
Printed Name of PATIENT

\_\_\_\_\_  
Signature of PARENT/GUARDIAN

\_\_\_\_\_  
Date

## CERTIFICATION

To the best of my knowledge, the previous information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health and/or insurance coverage

\_\_\_\_\_  
Printed Name of PATIENT

\_\_\_\_\_  
Signature of PATIENT or PARENT/GUARDIAN

\_\_\_\_\_  
Date

## PATIENT FINANCIAL POLICY

This office had adopted a financial policy that is outlined. If you have any questions regarding this policy, please discuss them with our office manager.

- Unless other arrangements have been made in advance by either you or your insurance carrier, full payment is due at the time of services are rendered.

### Your Insurance

- We have made prior arrangements with many insurance carriers to accept assignment of benefits. This means that we will bill those plans for which we have an arrangement and will only require you to pay the authorized co-payment at the time of service. It is the policy of our office to collect this co-payment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have prior arrangement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer may send the payment directly to you. Consequently, the charges for your care and treatment may be due at the time of service.

In the event that your health plan determines a service to be not covered, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

### Minor Patients

- For all services rendered to minor patients, responsibility will fall to the adult accompanying the patient or the parent or guardian with custody for payment.

I hereby authorize Dr. Jonathan Goff to use other diagnostic aids to make a thorough diagnosis of my chiropractic needs. I have answered all questions concerning my medical health history to the best of my knowledge.

- I authorize the release of my medical records to secure payment of insurance benefits.
- I authorize my insurance company to assign benefits to Back and Body Chiropractic for payment of services rendered.
- I authorize the use of this signature on all insurance submissions.
- I have read the copy of the privacy policy information and will/have reviewed the information.

Please note that a cancellation fee will be charged unless notice is given 24 hours prior to a scheduled appointment.

A \$25.00 fee will be charged for any returned check plus any recovery fees that may be incurred.

I have read and understand the Financial Policy, Signature Authorization, and Privacy Policy, and I agree to its terms and definitions. I also understand and agree that such terms may be amended from time to time by the practice.

\_\_\_\_\_  
Printed Name of PATIENT

\_\_\_\_\_  
Signature of PATIENT or PARENT/GUARDIAN

\_\_\_\_\_  
Date