

Today's Date / / 2016

CONFIDENTIAL PATIENT REGISTRATION

Last name First MI

Date of birth / / Age ___ Male ___ Female ___ Married ___ Single ___ Divorced

Street address

City State Zip

Phone Mobile Email

Employer/company Phone

Spouse's name Date of Birth / /

Spouse's employer

Emergency contact name Relationship Phone

Insurance company name Group number

Subscriber's name Birthdate / / ___check if same as above

Subscriber's relationship to patient

Do you have additional insurance? ___Yes ___No *If yes, complete the section below*

Secondary Insurance company name Group number

Subscriber's name Birthdate / / ___check if same as above

Subscriber's relationship to patient

I understand that I am financially responsible for all charges on the day of service whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. Dr. David J Schimp DC has permission to use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of submitting insurance claims (if insurance provides reimbursement for services the payment should come directly to you from your carrier).

Signature of patient, parent, guardian or personal representative _____

Print name _____ Date ___ / ___ / ___ Relationship _____

What is the reason for your visit (you can mark the diagram)

Rate the severity of your pain (0=no pain, 10 = severe pain) 0 1 2 3 4 5 6 7 8 9 10

When did your symptoms begin? ___/___/___ ___Sudden ___Gradual

Do you know what caused your problem (please describe)? ___Lifting ___Twisting ___Bending ___Trauma ___Unknown

Describe your pain ___Sharp ___Dull ___Aching ___Shooting ___Focal ___Diffuse ___Throbbing ___Numbness ___Stiffness
 ___Burning ___Tingling ___Cramps ___Swelling Other:

Frequency ___Constant ___0-25% of the time ___25-50% of the time ___50-75% of the time ___75% plus

What aggravates your pain? ___Sitting ___Standing ___Bending ___Lifting ___Cough/Sneeze ___Twisting ___Reaching
 Other:

Describe how your condition affects your daily life (i.e. what can't you do now because of your pain).

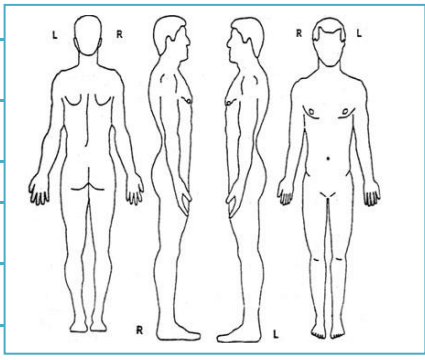
What relieves your symptoms? ___Heat ___Ice ___Rest ___Medication ___Activity
 Other:

Have you had this condition before? ___Yes ___No

Have you been treated by another doctor for this condition (please describe)?

Do you have any other health concerns?

Prior treatments ___None ___Medications ___Surgery ___Physical Therapy ___Chiropractic



Name/s of other doctors (facility): Recent medical examinations, images, labs:

| Associated Symptoms | | | | | | | | | | | |
|-----------------------------------|-----|----|---------------------|-----|----|--------------------|-----|----|----------------------------|-----|----|
| Fever, chills, night sweats | Yes | No | MEDICATIONS | | | | | | | | |
| Loss of appetite | Yes | No | 1. | | | | | | | | |
| Weight loss | Yes | No | 2. | | | | | | | | |
| Nausea/vomiting | Yes | No | 3. | | | | | | | | |
| Double, blurred, dim vision | Yes | No | 4. | | | | | | | | |
| Dizziness, ringing in ears | Yes | No | 5. | | | | | | | | |
| Nose or throat problems | Yes | No | 6. | | | | | | | | |
| Heart palpitations | Yes | No | 7. | | | | | | | | |
| Shortness of breath | Yes | No | 8. | | | | | | | | |
| Constipation | Yes | No | ALLERGIES | | | | | | | | |
| Diarrhea | Yes | No | 1. | | | | | | | | |
| Bloody stool or urine | Yes | No | 2. | | | | | | | | |
| Frequent urination | Yes | No | 3. | | | | | | | | |
| Burning with urination | Yes | No | 4. | | | | | | | | |
| Loss of bowel or bladder control | Yes | No | 5. | | | | | | | | |
| Loss of strength in arms or legs | Yes | No | SUPPLEMENTS | | | | | | | | |
| Loss of sensation in arms or legs | Yes | No | 1. | | | | | | | | |
| Swelling in arms or legs | Yes | No | 2. | | | | | | | | |
| Current smoker | Yes | No | 3. | | | | | | | | |
| Past smoker >100 cigarettes | Yes | No | 4. | | | | | | | | |
| Coffee/caffeine use | Yes | No | 5. | | | | | | | | |
| High stress 1 2 3 4 5 6 7 8 9 10 | Yes | No | FAMILY HISTORY | | | | | | | | |
| Exercises daily | Yes | No | 1. | | | | | | | | |
| Work duties | Yes | No | 2. | | | | | | | | |
| Pregnant | Yes | No | 3. | | | | | | | | |
| Recent surgery | Yes | No | 4. | | | | | | | | |
| Health History | | | | | | | | | | | |
| AIDS/HIV | Yes | No | Diabetes | Yes | No | Liver disease | Yes | No | Rheumatoid arthritis | Yes | No |
| Alcoholism | Yes | No | Emphysema | Yes | No | Measles | Yes | No | Rheumatic fever | Yes | No |
| Allergy Shots | Yes | No | Epilepsy | Yes | No | Migraines | Yes | No | Scarlet fever | Yes | No |
| Anemia | Yes | No | Fractures | Yes | No | Miscarriage | Yes | No | Sexual transmitted disease | Yes | No |
| Anorexia | Yes | No | Glaucoma | Yes | No | Mononucleosis | Yes | No | Stroke | Yes | No |
| Appendicitis | Yes | No | Goiter | Yes | No | Multiple sclerosis | Yes | No | Suicide attempt | Yes | No |
| Arthritis | Yes | No | Gonorrhea | Yes | No | Mumps | Yes | No | Thyroid disorder | Yes | No |
| Asthma | Yes | No | Gout | Yes | No | Osteoporosis | Yes | No | Tonsillitis | Yes | No |
| Bleeding disorder | Yes | No | Heart disease | Yes | No | Pacemaker | Yes | No | Tuberculosis | Yes | No |
| Breast lump | Yes | No | Hepatitis | Yes | No | Parkinson's | Yes | No | Tumors, growth | Yes | No |
| Bronchitis | Yes | No | Hernia | Yes | No | Pinched nerve | Yes | No | Typhoid fever | Yes | No |
| Bulimia | Yes | No | Herniated disk | Yes | No | Pneumonia | Yes | No | Ulcers | Yes | No |
| Cancer | Yes | No | Herpes | Yes | No | Polio | Yes | No | Vaginal infection | Yes | No |
| Cataracts | Yes | No | High blood pressure | Yes | No | Prostate problems | Yes | No | Whooping cough | Yes | No |
| Chemical dependency | Yes | No | High cholesterol | Yes | No | Prosthesis | Yes | No | | Yes | No |
| Chicken pox | Yes | No | Kidney disease | Yes | No | Psychiatric care | Yes | No | | Yes | No |
| Other | | | | | | | | | | | |