Registration and History

Patient Information

Date__/__/_____ Name_____ Home Phone ( ) _____Cell _____

Address _____ City _____ State _____ Zip _____

Sex: □ **M** □ **F** Age _____ Birthdate ___/___/_____ Patient SS# _____

Occupation _____ Employer _____

Work Phone ( )_____

□**Single** □**Married** □**Widowed** Spouse's Name_____ Birthdate ___/___/____

Insurance

Insurance Co. _____ ID# _____ Group#_____

Who is responsible for insurance? □ **Self** □ **Spouse** □ **Parent**

Name_____ Birthdate___/___/_____

Additional Insurance? □ Yes □ No

Insurance Co._____ ID#_____ Group#_____

Who is responsible for insurance? □ **Self** □ **Spouse** □ **Parent**

Name_____ Birthdate___/___/_____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
And assign directly to Dr. Oncken all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ ___/___/_____

Responsible Party **Signature** Relationship Date

Patient Condition

Reason for Visit _____ When did symptoms appear _____

Is this condition getting progressively worse? □ **Yes** □ **No** □ **Other**

Rate your Pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain: □ **Sharp** □ **Dull** □ **Throbbing** □ **Numbness** □ **Aching** □ **Shooting**
□ **Burning** □ **Tingling** □ **Cramps** □ **Stiffness** □ **Swelling** □ **Other**

How often do you experience your symptoms?

□**Constantly** (76%-100% of time) □**Frequently** (51%-75% of time) □**Occasionally** (26%-50% of time) □**Intermittently** (0%-25% of time)

Does it interfere with your □ **Work** □ **Sleep** □ **Daily Routine** □ **Recreation?**

Activities or movement that are painful □ **Sitting** □ **Standing** □ **Walking** □ **Bending** □ **Lying Down**

Health History

What treatment have you already received for your condition?

□ **Medications** □ **Surgery** □ **Physical Therapy** □ **Chiropractic Services** □ **None** □**Other**_____

Date of Last Physical Exam_____ Spinal X-ray_____ MRI, CT-Scan_____

Check the box if you had any of the following:

□**Cancer** □**Polio** □**Tuberculosis** □**Diabetes** □**Hepatitis** □**Measles** □**Muscular Dystrophy**

□**Convulsions/Epilepsy** □**Multiple Sclerosis** □**Arthritis** □**Neuritis** □**Herniated Disk** □**HIV**

□**Fractures** □**Concussion** □**Gout** □**Stroke** □**High Blood Pressure** □**Asthma** □**Migraine Headaches**

Are you pregnant? □ **Yes** □ **No** Due Date __/__/____

Accidents: Injuries/surgeries

Accident_____

Broken Bones_____ Falls_____

Head Injuries_____ Surgeries_____

Medications:_____

_____

Habits □ **Smoking** Packs/Day_____ □ **Alcohol** Drinks/Week_____

□ **Coffee/Caffeine Drinks** Cups/Day_____ □ **High Stress Level** Reason_____

PATIENT ACKNOWLEDGMENT

Patient Name:_____ Date:_____

Patient Address:_____

Patient Phone #:_____

The undersigned patient does hereby acknowledge that he/she has not been solicited by any employee or associate of Emerald City Chiropractic, LLC. The patient initiated contact with Dr. Nathaniel Christian Oncken and/or Emerald City Chiropractic, LLC willingly and without coercion. There have been no solicitation requests or advertisements received by the patient from Dr. Nathaniel Christian Oncken and/or Emerald City Chiropractic, LLC.

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Patient Signature