



Patient Name: _____ Acct#: _____

Whom may we thank for referring you to this office? _____

REGISTRATION FOR CARE AT HEALTHQUEST, INC.

Today's Date: _____ Acct#: _____

PATIENT DEMOGRAPHICS- *Please print clearly. ALL spaces must be filled in, or write "n/a". Thank you*

Name: _____ Birth Date: _____ Age: _____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Preferred method of communication for Patient Reminders: Email Phone Mail

Cell Ph Carrier (circle): ATT/Verizon/Sprint/Boost/Cricket/Nextel/T-mobile/ _____ (used for text messaging reminders)

_____ (please initial) I authorize HealthQuest to contact me via direct mail, e-mail, mobile text message (Message and Data Rates May Apply), or telephone (including pre-recorded telephone calls) for purposes of appointment reminders, health messages or current in-office specials that may be of interest to me. I understand that I can opt-out of these communications at any time by informing the front desk.

Ethnicity: Non-Hispanic/Latino Hispanic/Latino I Decline to Answer Preferred Language: English Other:

Marital Status: Single Married Divorced Widowed # of child(ren) and ages: _____

Race: White/Caucasian Black/African American Asian Amer. Indian/Alaska Native
 Native Hawaiian/Pacific Islander I Decline to Answer

Social Security #: _____ Driver's License #: _____ (please provide DL so we can copy)

Employer: _____ Work Address: _____ Work Phone: _____

Do you have Insurance: No Yes If yes, name of Ins Co: _____ ID#: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Legal Assignment of benefits and release of Medical and Plan Documents: In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to HealthQuest all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the Doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such Doctor and Clinic any and all plan documents, insurance policy and/or settlement information upon written request from such Doctor and Clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named Doctor and Clinic to the full extent permissible under the law and under any applicable insurance policies and/or any employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named Doctor and Clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such Doctor and Clinic in any attempts by such Doctor and Clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such Doctor and Clinic against such insurers and/or employee health care plan in my name but at such Doctor and Clinic's expense. Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be as valid as the original. I have read and fully understand this agreement.

Patient (or Authorized Person's) Signature Date Completed Doctor's Signature Date Form Reviewed



Patient Name: _____ Acct#: _____

REVIEW OF SYSTEMS- mark symptoms you have experienced in the past 30 days Date: _____

Head: <input type="checkbox"/> Headaches <input type="checkbox"/> Faintness <input type="checkbox"/> Dizziness <input type="checkbox"/> Insomnia	Energy/Activity/Mood: <input type="checkbox"/> Fatigue/Sluggishness <input type="checkbox"/> Apathy/Depression <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Anxiety/Fear/Nervousness	Nose: <input type="checkbox"/> Stuffy Nose <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Sneezing Attacks <input type="checkbox"/> Excessive Mucus Formation
Joints / Muscles: <input type="checkbox"/> Pain or aches in joints <input type="checkbox"/> Arthritis <input type="checkbox"/> Stiffness/limited movement <input type="checkbox"/> Pain / aches in muscles <input type="checkbox"/> Feeling of weakness or tiredness	Weight: <input type="checkbox"/> Binge Eating/Drinking <input type="checkbox"/> Craving Certain Foods <input type="checkbox"/> Excessive Weight <input type="checkbox"/> Compulsive Eating <input type="checkbox"/> Water Retention <input type="checkbox"/> Underweight	Digestive Tract: <input type="checkbox"/> Nausea, Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloating Feeling <input type="checkbox"/> Belching, Passing Gas <input type="checkbox"/> Heartburn

HISTORY of YOUR COMPLAINT

Please identify the MAIN condition(s) that brought you to this office: _____

Ever had spinal surgery? No Yes If Yes: Disc/Laminectomy Fusion (metal plates) Neck Mid back low back

On a scale of 0 to 10 with 0=Worst and 10=Best, rate how well you think you are doing with the following?:

Exercise _____ Sleep _____ Diet _____ Stress Level _____ Water Intake _____ Energy Level _____ = _____

Are you currently taking any medications? Yes No *(Include regularly used over-the-counter meds)

<u>Medication / Herb / Supplement</u>	<u>Dosage and Frequency</u> (i.e. 5 mg once a day, etc)	<u>Reason for Taking</u>
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SOCIAL HISTORY

Smoking: Never smoked Former smoker (quit date: _____) Current smoker (___ packs/day) year started _____

Alcoholic Beverage: beer wine liquor How often? Daily Weekends Occasionally Never

Recreational Drug use: No Yes (list drugs used) _____

FAMILY HISTORY:

Which health conditions run in your family? (please list relative after each disease) None

<input type="checkbox"/> heart disease (who _____)	<input type="checkbox"/> stroke (who _____)	<input type="checkbox"/> cancer (who _____)
<input type="checkbox"/> high blood pressure (who _____)	<input type="checkbox"/> arthritis (who _____)	<input type="checkbox"/> obesity (who _____)
<input type="checkbox"/> diabetes (who _____)	<input type="checkbox"/> osteoporosis (who _____)	<input type="checkbox"/> scoliosis (who _____)
<input type="checkbox"/> thyroid conditions (who _____)	<input type="checkbox"/> other _____	

POSSIBLE CONTRAINDICATIONS TO TREATMENT: None

Please review and mark any of these conditions which you experience, as they are potential risk factors to chiropractic care

- | | |
|---|---|
| <input type="checkbox"/> Joint hypermobility | <input type="checkbox"/> Unstable Os Odontoideum (C2 vertebra) |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Spinal Bone infection |
| <input type="checkbox"/> Benign tumors (spinal bones) | <input type="checkbox"/> Malignant cancers involving the spine |
| <input type="checkbox"/> Bleeding disorders or anticoagulant therapy | <input type="checkbox"/> Cauda Equine Syndrome (saddle numbness) or myelopathy |
| <input type="checkbox"/> Radiating pain with progressive neurological signs | <input type="checkbox"/> Acute fractures and dislocations |
| <input type="checkbox"/> Vertebrobasilar Artery Syndrome | <input type="checkbox"/> Acute arthropathy (incl. rheumatoid or Ankylosing Spondylitis) |
| | <input type="checkbox"/> Significant major artery aneurysm in area of complaint |

Patient signature Date

Doctor signature Date