

Lakeside Chiropractic

Patient Registration and History

1 Patient Information

Date _____ SS # _____

Patient Name _____
Last Name

First Name _____ Middle _____

Address _____

City _____

State _____ Zip _____

Sex M F Age _____

Email _____

Birthdate _____

Married Widowed Single Minor
 Separated Divorced Partnered for _____ Yrs

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS # _____

Spouse's Employer _____

Whom may we thank for referring you?

2 Insurance Information

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____ Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS # _____

Relationship to Patient _____

Insurance Co. _____ Group # _____

ASSIGNMENT AND RELEASE
 I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Cindy Pradhan 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will and when my current treatment plan is completed or one year from the date signed below.

 Signature of Patient, Parent, Guardian or Personal Representative

 Please print name of Patient, Parent, Guardian or Personal Representative

 Date

 Relationship to Patient

3 Phone Numbers

Cell (_____) _____ Home (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home (_____) _____ Work (_____) _____

4 Accident Information

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp Other

Attorney Name (if applicable) _____

5 Patient Condition

Reason for Visit _____

When did the symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

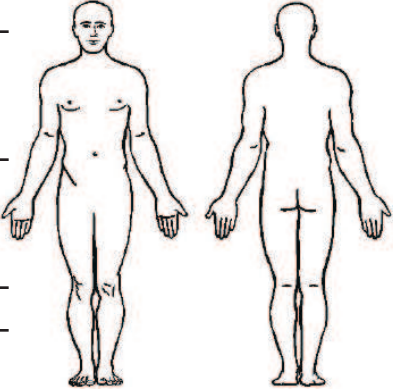
Type of Sharp Dull Throbbing Numbness Aching Shooting
 pain: Burning Cramps Tingling Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down



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Health History

What treatment have you already recieved for condition? Medications Surgery Physical Therapy
 Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition. _____

Date of last:

Physical Exam _____ Spinal X-Ray _____ Blood Test _____ Dental X-Ray _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsilitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Exercise

- None
- Moderate
- Daily
- Heavy

Work Activity

- Sitting
- Standing
- Light Labor
- Heavy Labor

Habits

- Smoking Packs per Day _____
- Alcohol Drinks per Week _____
- Caffeinated Drinks Cups per Day _____
- High Stress Level Reason _____

Pregnancy

- Are you pregnant?
- Yes Due Date _____
 - No

Injuries/Surgeries you may have had:	Description	Date
Falls _____	_____	_____
Head Injuries _____	_____	_____
Broken Bones _____	_____	_____
Dislocations _____	_____	_____
Surgeries _____	_____	_____

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Medications

Allergies

Vitamins/Herbs/Minerals

_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____