Windham Chiropractic, LLC

Patient Registration Form

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. (check one) Today's Date: ___/___/_____

First Name: _____ Middle Initial:____ Last Name: _____

Date of Birth: ___/___/_____ Sex: ◯ Male ◯ Female ◯ Non-Binary

Address Line 1: _____

Address Line 2: _____

City: _____ State:_____ Zip Code: _____

Cell Phone: (____) ____ - _____ Email Address: _____

Emergency Contact Name: _____

Emergency Contact Phone: (____)____ - _____ Relationship: _____

Do you have Health Insurance coverage right now? ◉ Yes ◯ No (If "No" skip to page 2 on the back of this sheet)

Subscriber's Name:_____ Date of Birth ____/____/_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other_____

I, the undersigned, certify that I have insurance coverage and assign directly to Windham Chiropractic, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand Dr. St. Onge Jr may not be a provider for my insurance and I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature:_____ Date:___/___/_____

I, the undersigned, understand that I am financially responsible for any and all services rendered in the office. Payment can be made with cash, check, or credit card. If I know I can't afford my treatment, I will tell the doctor and discuss my payment options.

Signature: _____ Date:___/___/_____

What is your **reason for coming to this office**? (Mark all that apply)

- ☐ Become pain free
- ☐ Learn how to care for my condition
- ☐ Resume normal activity level
- ☐ Explanation or diagnosis of my symptom(s)
- ☐ Reduce symptoms
- ☐ Maintain current level of health

Circle any **Allergies**:

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs ☐ Latex ☐ Molds
☐ Penicillin ☐ Ragweed/Pollen ☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat
☐ X-Ray Dye Other:_____

Circle any Areas on Which You Have Had **Surgery**:

☐ Back ☑ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Shoulder ☐ Wrist ☐ Other

Please provide Details Including Dates: _____
_____

Please put a checkmark next to **ALL Past or Present Medical Conditions**:

☐	Ankle Pain	☐	Arm Pain	☐	Asthma	☐	Back Pain
☐	Broken Bones	☐	Cancer	☐	Chest Pain	☐	Depression
☐	Diabetes	☐	Dizziness	☐	Elbow Pain	☐	Epilepsy
☐	Eye/Vision Problems	☐	Fainting	☐	Fatigue	☐	Foot Pain
☐	Genetic Spinal Condition	☐	Hand Pain	☐	Headaches	☐	Hearing Problems
☐	Hepatitis	☐	High Blood Pressure	☐	Hip Pain	☐	HIV
☐	Jaw Pain	☐	Joint Stiffness	☐	Knee Pain	☐	Leg Pain
☐	Menstrual Problems	☐	Mid-Back Pain	☐	Minor Heart Problem	☐	Multiple Sclerosis
☐	Neck Pain	☐	Neurological Problems	☐	Pacemaker	☐	Parkinson's Disease
☐	Prostate Issues	☐	Shoulder Pain	☐	Significant Weight Change	☐	Spinal Cord Injury
☐	Stroke/Heart Attack						

Other: _____

Please List Any **Medications** you are taking:

_____

_____

_____

Are you pregnant or do you think you may be pregnant? ◯ NO ◯ YES

Is your visit today related to an **auto accident** or **work injury**? ◯ **NO** ◯ **YES**

Please Describe the Accident: _____

_____

_____

Date of last physical examination: _____

Do you smoke? ◯ No ◯ Yes - how much per day? _____
Do you drink alcohol? ◯ No ◯ Yes - how many drinks per day? _____
Do you drink caffeine? ◯ No ◯ Yes - how much per day? _____
Do you exercise? ◯ No ◯ Yes - what forms and how often? _____

_____

Have you ever had chiropractic care? ◯ No ◯ Yes
When? _____ Why? _____
Where? _____ Were X-rays taken? _____
When was your last adjustment? _____

What is your **MAJOR complaint**? _____ Date problem began_____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ◯ Getting Better ◯ Getting Worse ◯ Not Changing

Have you had this condition in the past? ◯ Yes ◯ No

How often do you experience your symptoms? Please circle your answer.

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

Please circle the nature of your symptoms:
Sharp Dull Numb Burning Shooting Tingling Radiating Pain Tightness
Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0 = no pain and 10 = excruciating pain) _____

How do your symptoms affect your ability to perform daily activities such as working or driving?
(0 = no effect and 10 = no possible activities) _____

What activities aggravate your condition (working, exercise, etc.)? _____

What makes your pain better (ice, heat, massage, etc.)? _____

What is your **SECOND complaint**? _____ Date problem began_____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? Getting Better Getting Worse Not Changing

Have you had this condition in the past? Yes No

How often do you experience your symptoms? Please circle your answer.
Constantly (76-100% of the time) Frequently (51-75% of the time)
Occasionally (26-50% of the time) Intermittently (0-25% of the time)

Please circle the nature of your symptoms:
Sharp Dull Numb Burning Shooting Tingling Radiating Pain Tightness
Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0 = no pain and 10 = excruciating pain) _____

How do your symptoms affect your ability to perform daily activities such as working or driving?
(0 = no effect and 10 = no possible activities) _____

What activities aggravate your condition (working, exercise, etc.)? _____

What makes your pain better (ice, heat, massage, etc.)? _____

Do you have any other complaints?

Patient Signature _____ Date___/___/_____