Windham Chiropractic, LLC

Patient Registration Form

Today's Date:

Title: First Name: Last Name:

Date of Birth: Gender:

Address Line 1: Address Line 2:

City: State: NH Zip Code:

Phone Number: Email Address:

Emergency Contact Name: Relationship:

Emergency Contact Phone:

Do you have Health Insurance Coverage Right Now?

Subscriber Name: Date of Birth:

Relationship to Patient:

Insurance Company Name: Group #:

I, the undersigned, certify that I have health insurance coverage and assign directly to Windham Chiropractic, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand Dr. Barry St. Onge, Jr. may not be a provider for my insurance and I am financially responsible for all charges whether or not paid by my 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 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?

Please select any allergies: ☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs ☐ Latex ☐ Mold ☐ Penicillin ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat ☐ X-Ray Dye ☐ Other:

Please describe any surgeries you have had and when:

Please put a check mark 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
- ☐ 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:

Please put a check mark next to any known conditions in your family history:

- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Genetic Spinal Condition
- ☐ High Blood Pressure
- ☐ Heart Problems
- ☐ Multiple Sclerosis
- ☐ Neurological Problems
- ☐ Parkinson's Disease
- ☐ Prostate Issues
- ☐ Stroke/Heart Attack
- ☐ Other

Are you pregnant or do you think you may be pregnant? ☐ Yes ☐ No

Is your visit today related to an auto accident or work injury? ☐ Yes ☐ No

Please describe the accident:

Date of last physical examination:

Do you smoke? ☐ No ☐ Yes How Much?

Do you drink alcohol? ☐ No ☐ Yes How Much?

Do you drink caffeine? ☐ No ☐ Yes How Much?

Do you exercise? ☐ No ☐ Yes What forms and how often?

Have you ever had chiropractic care? ☐ No ☑ Yes

If so, 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?

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 select 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?

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 select the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning
☐ Shooting ☐ Tingling ☐ Radiating Pain ☐ Tightness ☐ 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: