**Please Fill Out COMPLETELY. The more information we have, the better we can help you. Thank you.**

## Patient Registration *(please print clearly)*

First Name:_____ MI____ Last Name:_____Date___/___20___

Address_____City_____ State_____Zip_____

Home Phone(____)-_____-_____ Cell Phone (____)-_____-_____Work Phone(____)-_____-_____

Date of Birth_____/_____/_____ Age _____ Soc. Security #_____-_____-_____

Drivers License #_____ Email Address_____

Are you: □ Married □ Single □ Domestic Partnership □Minor

Spouses Name:_____ # of Children_____ Emergency Contact_____

Relationship_____Phone:(____)_____-_____

Occupation_____Employer_____Work Number_____

Your Health InsuranceCompany_____Phone Number (____)-_____-_____

ID #:_____Group #:_____Name of Insured:_____

Relationship to you:_____

Person Responsible for Charges_____

## Symptoms / Health History

How did you hear about us?_____

Reason for visit:_____ When did you first notice symptoms?_____

Is the condition getting better / same / progressively worse? (circle one)

Type of pain: ☐Sharp ☐Dull ☐Burning ☐Aching ☐Cramps ☐Throbbing ☐Tingling ☐Shooting ☐Other

What treatment have you received for your condition? ☐Medication ☐ Chiropractic ☐ Surgery ☐ Other

Are you or have you ever been under Chiropractic care? _____

List all medications you are currently taking:_____

What type of exercise do you perform on a daily basis? ☐None ☐Moderate ☐Heavy :_____

List hospitalizations or surgeries you have had with corresponding dates:

_____Date: ____/____/_____ _____Date: ____/____/_____

List other injuries including falls and other traumas and when they occurred:

_____Date: ____/____/_____ _____Date: ____/____/_____

Have you been diagnosed with any diseases or disorders and when?

_____Date: ____/____/_____ _____Date: ____/____/_____

## Review of Symptoms

Weight _____ Weight 1 yr. ago _____ Max. Weight _____When_____

**Please Circle the appropriate letter next to each item based on the following:**

**Y**= a condition you have now **N**= never had

| | | | | | |
|---|---|---|---|---|---|
| Headache | Y | N | Pneumonia | Y | N |
| Neck Pain | Y | N | Emphysema | Y | N |
| Back Pain | Y | N | Difficulty Breathing | Y | N |
| Lower Back Pain | Y | N | Shortness of Breath | Y | N |
| Extremity Pain | Y | N | Heart Disease | Y | N |
| Chest Pain | Y | N | Angina | Y | N |
| Right/Left Arm Pain/ Numbness | Y | N | High Blood Pressure | Y | N |
| Right/Left Leg Pain/ Numbness | Y | N | Swollen Ankles/Stomach | Y | N |
| Right/Left Foot Pain/ Numbness | Y | N | Hip/Joint Replacement | Y | N |
| Right/Left Hand Pain/ Numbness | Y | N | Nausea | Y | N |
| Fingers/Toes Pain/ Numbness | Y | N | Vomiting | Y | N |
| Spasms | Y | N | Constipation | Y | N |
| Dizziness | Y | N | Blood in Stool | Y | N |
| Blurry Vision | Y | N | Gas/Bloating | Y | N |
| Motion Restriction | Y | N | Liver Disease | Y | N |
| Radiating Symptom | Y | N | Hemorrhoids | Y | N |
| Sleep Disruption | Y | N | Abdominal Pain | Y | N |
| Anxiety | Y | N | Peptic Ulcer | Y | N |
| Night Sweats | Y | N | Gall Bladder Disease | Y | N |
| Headaches | Y | N | Pain on Urination | Y | N |
| Head Injury | Y | N | Urinary Frequency | Y | N |
| Impaired Vision | Y | N | Ligament or Tendon repair | Y | N |
| Corrected Vision | Y | N | Kidney Stones | Y | N |
| Depression | Y | N | Blood in Urine | Y | N |
| Tearing/Dryness | Y | N | Joint Pain/Stiffness | Y | N |
| Double Vision | Y | N | Arthritis | Y | N |
| Jaw Pops/Clicks/Painful | Y | N | Broken Bones | Y | N |
| Cataracts | Y | N | Muscle Spasms | Y | N |
| Impaired Hearing | Y | N | Deep Leg Pain | Y | N |
| Ear Ringing | Y | N | Blood Clots in Legs | Y | N |
| Earaches | Y | N | Aspiration of Hematoma | Y | N |
| Frequent Colds | Y | N | Fainting | Y | N |
| Sinusitis | Y | N | Seizures | Y | N |
| Postnasal Drip | Y | N | Paralysis | Y | N |
| Change in Taste | Y | N | Muscle Weakness | Y | N |
| Thyroid Problems | Y | N | Numbness/Tingling | Y | N |
| Cough | Y | N | Coordination Difficulties | Y | N |
| Sputum | Y | N | Depression | Y | N |
| Spit up Blood | Y | N | Anxiety | Y | N |
| Asthma | Y | N | Mood Swings | Y | N |
| Bronchitis | Y | N | Memory Loss | Y | N |

| | | |
|---|---|---|
| Drug/Alcohol Abuse | Y | N |
| Difficulty Sleeping | Y | N |
| Phobia | Y | N |
| Thyroid Problem | Y | N |
| Extremity Pain – Numbness | Y | N |
| Knee Surgery | Y | N |
| Excessive Thirst | Y | N |
| Excessive Hunger | Y | N |
| Anemia | Y | N |
| Easy Bleeding | Y | N |

Number of pregnancies _____

Do you Smoke? Y N

How much per day? _____

Do you drink alcohol? Y N

How much weekly? _____

**Females Only**

Age menses began _____

Age menses ended _____

Average cycle length _____

Average bleeding length _____

| | | |
|---|---|---|
| Spotting | Y | N |
| Irregular Cycles | Y | N |
| Painful Menses | Y | N |
| Birth Control | Y | N |
| Sexual Difficulties | Y | N |
| STD | Y | N |
| Breast Lumps | Y | N |
| Breast Pain | Y | N |
| Nipple Discharge | Y | N |

I am Pregnant ____Yes ____No

Due Date: _____

Number of miscarriages _____

Number of live births _____

Are you HIV positive / AIDS?

☐ YES ☐ NO ☐ Don't Know

**Are there any additional health concerns or questions that you may have?**

_____

_____

_____

_____

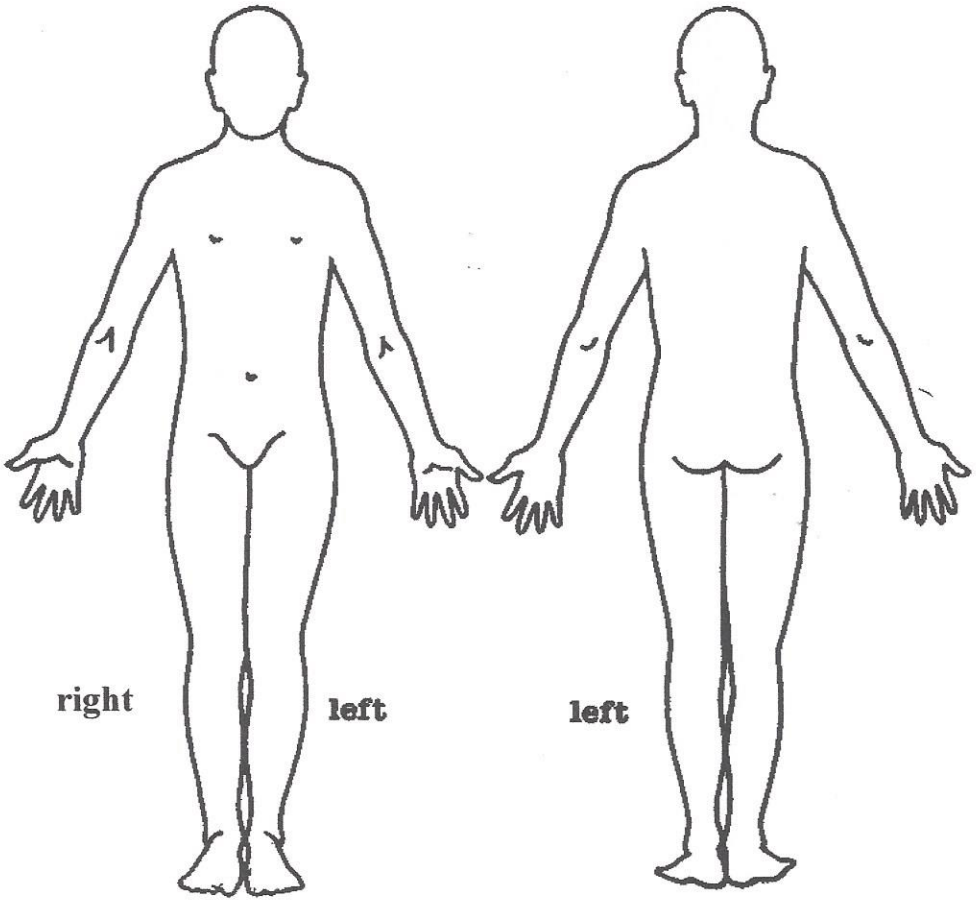
**Use the picture below to indicate your problem areas. Use the appropriate symbol to indicate numbness, pins & needles, burning, aching or weakness.**

Numbness, Pins & Needles: **N**

Aching pain: **A**

Burning: **B**

Weakness: **W**




**Please rate your discomfort on a scale of 1-10.**

(1= mild pain, 10=the worse pain you've ever felt).

| | Location | Pain rating |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

# AUTHORIZATION FOR CARE
# ASSIGNMENT OF INSURANCE BENEFITS

## This is an agreement between the undersigned patient and Comprehensive Medical Center.

**I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.** Furthermore, I understand that Comprehensive Medical Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Comprehensive Medical Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care that my fees for professional services rendered to me by Comprehensive Medical Center will be immediately due and payable. ***I agree to accept responsibility for whatever is not covered or accepted by the insurance company; this will include any part of my deductible, which has not been met, co-pays or disallowed services.***

**I hereby authorize Comprehensive Medical Center to treat my condition, as the clinician deems appropriate including the use of diagnostic testing and prescribed treatment modalities.** Original x-rays taken at Comprehensive Medical Center will remain the property of Comprehensive Medical Center, being on file where they may be seen at any time while a patient of this office. Should I require copies of the films, I also agree to pay for the cost of duplication. Comprehensive Medical Center will not be held responsible for any pre-existing medically diagnosed conditions.

**I authorize and direct my insurance company, and/or my attorney, *to pay directly to Comprehensive Medical Center* such sums as may be due and owing Comprehensive Medical Center for services rendered me**, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefits, No-Fault benefits, health and accident benefits, Workmen's Compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office. I understand that if my treatment is the result of a personal injury, that Comprehensive Medical Center may have to provide additional documentation, depositions, and testimony. Because of this, I agree to pay Comprehensive Medical Center the full amount of all services at their usual and customary fees notwithstanding any agreements Comprehensive Medical Center may have with any other insurance companies/Health Maintenance Organizations, Preferred Provider Organizations, Point of Service carriers or healthcare entities or carriers of any kind. I agree that the above-mentioned office be given power of attorney to endorse/sign my name on any and all checks received for payment of my doctor bill.

**I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization.**
I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this office for all costs of such collections efforts, including but not limited to all reasonable court costs and all attorney fees. I grant Comprehensive Medical Center my permission to contact me in regards to my appointments and leave messages on my home, cell, or office.

| | |
|---|---|
| _____ | _____ |
| **Patient Name (Printed)** | Person Authorizing Care if other than Patient |
| _____ | ____/____/____ |
| **Signature** | **Date** |
| _____ | ____/____/____ |
| Witness | Date |

# HIPPA Privacy Authorization and Permission to Release Health Care Information

Please **BE SPECIFIC** with names

I, _____ (patient's name) hereby authorize Comprehensive Wellness Center, LLC to use/or disclose my protected healthcare information to and/or from the following:

☐ Parents: _____

☐ Spouse: _____

☐ Insured: _____

☐ Other: _____

I have been given the opportunity to read the HIPPA regulations and understand its contents. I understand Comprehensive Wellness Center, LLC will use and/or disclose this information in attempt to provide my medical care and/or payment for services.

_____**(Signature of Patient or authorized representative)**

_____**(Relationship to Patient)**

_____**(Date)**