CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Patient's Full Name:_____ Today's Date:_____

Street::_____ Apt No.:_____

City:_____State:_____ ZIP:_____

Birth date:_____/_____/_____ Age:_____ Sex: **Male** **Female**

Social Security#: _____

Marital Status: **Single** **Married** **Widowed** **Separated** **Divorced**

Home Phone:_____ Work Phone:_____

Cell Phone:_____ E Mail:_____

Best time and place to reach you:_____

Occupation:_____ Employer:_____

Employer Address:_____ Phone:_____

Spouse's Name:_____

Occupation:_____ Employer:_____

In Case Of Emergency, Contact:_____

Relationship:_____ Home Phone:_____ Cell or Work Phone:_____

PAYMENT INFORMATION

Who is responsible for this account?_____ Relationship to patient?_____

_____ I ***do not*** *have insurance coverage* for Chiropractic Care with Dr. Parmiter and I understand I am fully responsible for all charges and that payment is due when services are rendered, unless other payment arrangements have been established. I also understand a 5% interest charge may be charged per month on any outstanding balance. I agree to be responsible for court costs and an additional 33 1/3% of balance for attorney fees associated with the collections procedures brought by Health Links, Inc., should that be necessary. Any returned checks will be subject to a $25.00 service charge.

Signature_____ **Date:**_____

_____ I , the undersigned, certify that I (or my dependent) ***have*** *insurance coverage* with the carrier listed below. I assign directly to ***Dr. Jon K. Parmiter*** all insurance benefits, if any, otherwise payable to me for services rendered. ***I understand that I am fully responsible for all charges whether or not paid by insurance and that copayments or costshares are due at the time service is rendered, unless other arrangements have been established.*** . I also understand a 5% interest charge may be charged per month on any outstanding balance. I agree to be responsible for court costs and an additional 33 1/3% of balance for attorney fees associated with the collections procedures brought by Health Links, Inc., should that be necessary. Any returned checks will be subject to a $25.00 service charge.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature:_____ **Date:**_____

Insurance Carrier:_____ Member#_____Group#: _____

Subscriber:_____ Subscriber DOB :_____

Are you aware of the Chiropractic Benefits your policy offers? YES NO

Please complete next page

Patient name: _____ Date: _____

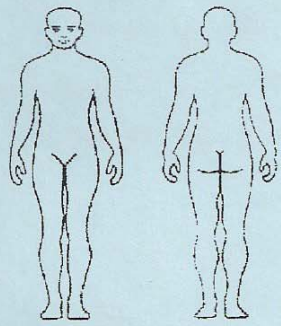
ACCIDENT INFORMATION

Is condition due to an accident? **NO YES** Type of accident? **AUTO WORK HOME OTHER**_____
To whom have you made a report of your accident? AUTO INSURANCE EMPLOYER WORKER COMP OTHER_____
Auto Insurance Company_____ **Agent/Phone**_____

Claim #:_____

Attorney Name/phone (if applicable):_____

PATIENT CONDITION



Reason for Visit_____

When did symptoms appear?_____

Is this condition getting progressively worse? **YES NO UNKNOWN**
How often do you have this pain?_____

Is it constant or does it come and go?_____
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 pain: (circle all that apply) **SHARP DULL THROBBING NUMBNESS ACHING SHOOTING BURNING TINGLING CRAMPS STIFFNESS SWELLING OTHER**_____

Does it interfere with your: **WORK SLEEP DAILY ROUTINE RECREATION**

Activities or movements that are painful to perform: **SITTING STANDING WALKING BENDING LYING DOWN**

HEALTH HISTORY

What treatment have you received for your condition?_____
Name of your Primary Care Physician _____ date last seen?_____
Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	__yes __no	Chemical Dependency	__yes __no	Herpes	__yes __no	Parkinson's Disease	__yes __no	Suicide Attempt	__yes __no
Alcoholism	__yes __no			High Cholesterol	__yes __no			Thyroid Problems	__yes __no
Allergy Shots	__yes __no	Chicken Pox	__yes __no	Kidney Disease	__yes __no	Pinched Nerve	__yes __no	Tonsillitis	__yes __no
Anemia	__yes __no	Diabetes	__yes __no	Liver Disease	__yes __no	Pneumonia	__yes __no	Tuberculosis	__yes __no
Anorexia	__yes __no	Emphysema	__yes __no	Measles	__yes __no	Polio	__yes __no	Tumors, Growths	__yes __no
Appendicitis	__yes __no	Epilepsy	__yes __no	Migraine Headaches	__yes __no	Prostate Problems	__yes __no	Typhoid Fever	__yes __no
Arthritis	__yes __no	Fractures	__yes __no	Miscarriage	__yes __no	Prosthesis	__yes __no	Ulcers	__yes __no
Asthma	__yes __no	Glaucoma	__yes __no	Mononucleosis	__yes __no	Psychiatric Care	__yes __no	Vaginal Infections	__yes __no
Bleeding Disorders	__yes __no	Goiter	__yes __no	Multiple Sclerosis	__yes __no	Rheumatoid Arthritis	__yes __no	Venereal Disease	__yes __no
Breast Lump	__yes __no	Gonorrhea	__yes __no	Mumps	__yes __no	Rheumatic Fever	__yes __no	Whooping Cough	__yes __no
Bronchitis	__yes __no	Gout	__yes __no	Osteoporosis	__yes __no	Scarlet Fever	__yes __no		
Bulimia	__yes __no	Heart Disease	__yes __no	Pacemaker	__yes __no	Stroke	__yes __no		
Cancer	__yes __no	Hepatitis	__yes __no						
Cataracts	__yes __no	Hernia	__yes __no						
		Herniated Disk	__yes __no						

Other_____

Exercise: **NONE MODERATE DAILY HEAVY**
Work Activity: **SITTING STANDING LIGHT LABOR HEAVY LABOR**
Habits: **SMOKING (____PACKS/DAY) ALCOHOL(____DRINKS/WEEK) CAFFEINE(__CUPS/DAY)**
HIGH STRESS(REASON_____)
Are you Pregnant? YES NO Due Date?_____
Injuries you have had and date?_____
Medications/Vitamins you are taking?_____