Patient Name: ______________________ Acct#: ______________

Whom may we thank for referring you to this office? ❑ ____________________________________

REGISTRATION FOR CARE AT HEALTHQUEST, INC.

Today's Date: ________________ Acct#:________________

PATIENT DEMOGRAPHICS- ***Please print clearly. ALL spaces must be filled in, or write "n/a". Thank you***

Name: __________________________________ Birth Date: ____________ Age: _____ ❑ Male ❑ Female

Address: ________________________________ City: ______________________ State: ____ Zip: _________

E-mail Address: ___________________________ Home Phone: _______________Mobile Phone:______________

Preferred method of communication for Patient Reminders: ❑ Email ❑ Phone ❑ Mail

Cell Ph Carrier (circle): ATT/Verizon/Sprint/Boost/Cricket/Nextel/T-mobile/__________ (used for text messaging reminders)

_____ (please initial) I authorize HealthQuest to contact me via direct mail, e-mail, mobile text message (Message and Data Rates May Apply), or telephone (including pre-recorded telephone calls) for purposes of appointment reminders, health messages or current in-office specials that may be of interest to me. I understand that I can opt-out of these communications at any time by informing the front desk.

Ethnicity: ❑ Non-Hispanic/Latino ❑ Hispanic/Latino ❑ I Decline to Answer Preferred Language: ❑ English ❑ Other:

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed # of child(ren) and ages: ______________

Race: ❑ White/Caucasian ❑ Black/African American ❑ Asian ❑ Amer. Indian/Alaska Native
❑ Native Hawaiian/Pacific Islander ❑ I Decline to Answer

Social Security #: ___________________ Driver's License #: _________________ (please provide DL so we can copy)

Employer: ___________________ Work Address: _____________________________ Work Phone: ____________

Do you have Insurance: ❑ No ❑ Yes If yes, name of Ins Co: ____________________ ID#: ____________________

Emergency Contact Name: _____________________ Phone: _________________Relationship: _________________

Legal Assignment of benefits and release of Medical and Plan Documents: In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to HealthQuest all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the Doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such Doctor and Clinic any and all plan documents, insurance policy and/or settlement information upon written request from such Doctor and Clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named Doctor and Clinic to the full extent permissible under the law and under any applicable insurance policies and/or any employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named Doctor and Clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such Doctor and Clinic in any attempts by such Doctor and Clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such Doctor and Clinic against such insurers and/or employee health care plan in my name but at such Doctor and Clinic's expense. Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be as valid as the original. I have read and fully understand this agreement.

____ ______________________________________

Patient (or Authorized Person's) Signature **Date Completed** **Doctor's Signature** **Date Form Reviewed**

Patient Name: ____________________ Acct#: ______________

REVIEW OF SYSTEMS- mark symptoms you have experienced in the past 30 days Date: ___________

Head:	**Energy/Activity/Mood:**	**Nose:**
______ **Headaches**	_____ **Fatigue/Sluggishness**	_____ **Stuffy Nose**
______ **Faintness**	_____ **Apapthy/Depression**	_____ **Sinus Problems**
______ **Dizziness**	_____ **Hyperactivity**	_____ **Sneezing Attacks**
______ **Insomnia**	_____ **Anxiety/Fear/Nervousness**	_____ **Excessive Mucus Formation**
Joints / Muscles:	**Weight:**	**Digestive Tract:**
_____ **Pain or aches in joints**	_____ **Binge Eating/Drinking**	______ **Nausea, Vomiting**
_____ **Arthritis**	_____ **Craving Certain Foods**	______ **Diarrhea**
_____ **Stiffness/limited movement**	_____ **Excessive Weight**	______ **Constipation**
_____ **Pain / aches in muscles**	_____ **Compulsive Eating**	______ **Bloated Feeling**
_____ **Feeling of weakness or tiredness**	_____ **Water Retention**	______ **Belching, Passing Gas**
	_____ **Underweight**	______ **Heartburn**

HISTORY of YOUR COMPLAINT

Please identify the MAIN condition(s) that brought you to this office: ____

____

Ever had spinal surgery? ❑ No ❑ Yes If Yes: ❑ Disc/Laminectomy ❑ Fusion (metal plates) ❑ Neck ❑ Mid back ❑ low back

On a scale of 0 to 10 with 0=Worst and 10=Best, rate how well you think you are doing with the following?:

Exercise_______ Sleep _______ Diet ________ Stress Level ______ Water Intake _______ Energy Level________ = ________

Are you currently taking any medications? ❑ Yes ❑ No *(Include regularly used over-the-counter meds)

Medication / Herb / Supplement	Dosage and Frequency (i.e. 5 mg once a day, etc)	Reason for Taking

SOCIAL HISTORY

Smoking: ❑ Never smoked ❑ Former smoker (quit date: ______) ❑ Current smoker (___ packs/day) year started_____

Alcoholic Beverage: ❑ beer ❑ wine ❑ liquor How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

Recreational Drug use: ❑ No ❑ Yes (list drugs used) ____

FAMILY HISTORY:

Which health conditions run in your family? (please list relative after each disease) ❑ None

- ❑ heart disease (who ____________)
- ❑ high blood pressure (who ___________)
- ❑ diabetes (who ___________)
- ❑ thyroid conditions (who ___________)
- ❑ stroke (who __________)
- ❑ arthritis (who ___________)
- ❑ osteoporosis (who ___________)
- ❑ other ______________________
- ❑ cancer (who ___________)
- ❑ obesity (who ___________)
- ❑ scoliosis (who ___________)

POSSIBLE CONTRAINDICATIONS TO TREATMENT: ❑ None

Please review and mark any of these conditions which you experience, as they are potential risk factors to chiropractic care

- ❑ Joint hypermobility
- ❑ Osteoporosis
- ❑ Benign tumors (spinal bones)
- ❑ Bleeding disorders or anticoagulant therapy
- ❑ Radiating pain with progressive neurological signs
- ❑ Vertebrobasilar Artery Syndrome
- ❑ Unstable Os Odontoideum (C2 vertebra)
- ❑ Spinal Bone infection
- ❑ Malignant cancers involving the spine
- ❑ Cauda Equine Syndrome (saddle numbness) or myelopathy
- ❑ Acute fractures and dislocations
- ❑ Acute arthropathy (incl. rheumatoid or Ankylosing Spondylitis)
- ❑ Significant major artery aneurysm in area of complaint

____ ____

Patient signature **Date** **Doctor signature** **Date**