PATIENT REGISTRATION

Name_____ Social Security #_____ Date: _____
Last First MI

Address_____
Number Street City ST Zip

Sex: M / F Age: _____ Birth Date: _____ Height:_____ Weight: _____

Home # _____ Work # _____Cell#_____ Single/Married/Divorced/Widow

Employer _____ Type of Work you do_____

In case of emergency contact_____ Relationship _____Phone # _____

Email: _____ How did you hear about us?_____

Preferred way of communication: Home / Cell / Work / Email / Text

HEALTH INSURANCE INFORMATION

Health Insurance Company: _____ Name of Insured: _____

Member #: _____ Group#: _____ Phone #: _____

TREATMENT OF MINOR

[ ] Not applicable
Guardian's Name_____Social Security #_____
Relationship to Patient _____ Home # _____ Work # _____
Address (if different) _____
Place of Employment _____

I hereby authorize Pow-Her Chiropractic and all it designates to treat this minor who is legally under my guardianship.

Signature_____ Date_____

RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and that it is my responsibility to notify this office of any changes. I further will not hold my doctor or any member of the staff responsible for any errors or omissions that I have made in the completion of this form.

I hereby authorize Pow-Her Chiropractic and or any of its subsidiaries to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions. I hereby authorize and assign directly to Pow-Her Chiropractic all insurance benefits, if any, payable to services rendered. I understand that I am responsible for all charges whether or not paid by insurance.

_____
Signature Date

_____
Witness Date

CLINICAL HISTORY

Circle if you have a history of any of the following:

Skin
Rash
Eczema
Itching
Skin Changes
Redness
Bruise easily
Hair changes

Neurologic
Headache
Dizziness
Fainting
Convulsion
Nervousness
Confusion
Numbness
Paralysis
Cold/tingling extremities

Eyes/Ears
Hearing trouble
Ringing
Vision Trouble
Pain
Discharge

Musculoskeletal
Neck pain
Upper back pain
Low back pain
Upper extremity pain
Lower extremity pain
Jaw pain
General stiffness
Walking problems

Nose
Pain
Bleeding
Sinus Problems
Infections
No Smell

Mouth/Throat
Sores
Bleeding
Tonsilitis
Enlarged Glands
No Taste
Abnormal Taste
Bad breath

Heart Lungs
Cough
Wheezing
Asthma
Difficulty Breath
Swollen UE/LE
Blue UE/LE
Varicosities
Murmur
Chest Pain
Palpitations

Breasts
Lumps
Redness/Itching
Pain
Dimpling
Discharge

Stomach/Digestion
Decreased Appetite
Increased Appetite
Abdominal Pain
Hemorrhoids
Excess Gas
Vomit
Diarrhea
Constipation

Genitourinary
Inability hold urine
Painful Urination
Frequent Urination
Bedwetting
Irregular Menstruation
Painful Menstruation
Abnormal Vaginal Bleeding
Prostate Problems
Sterility

Endocrine
Thyroid
Heat/Cold intolerance
Sugar in urine
Goiter
Tremor

Psychological
Anxiety
Depression
Phobia
Mood Swings
ADD/ADHD
Mental Disorders

Arthritis / Anemia / Cancer / Diabetes / Epilepsy / Gout / Gallbladder / Hypertension / Influenza / Kidney disease / Lupus /Nausea / Vomiting / TB / Polio / Migraines / Mumps / Multiple Sclerosis / Psoriasis / Rheumatoid Arthritis / Scoliosis / Hernia / Lyme Disease

Broken Bones Y/N Explain:_____

Pregnant: Y/N _____ Last Mammogram:_____ Last prostate exam:_____

Doctor's you have seen in past 2 years:_____

Surgeries you have had: _____

Allergies: _____

List Drugs or Supplements: _____

Children: (# & ages) _____

Smoker packs per day_____ Caffeine (soda,coffee,tea) cups per day _____

Alcohol per day/week: _____ Commute:_____

Hobbies:_____

List health conditions family members have/had:

Mother:_____ Father:_____
Sister:_____ Brother:_____
Grandparents:_____ Children:_____

Have you ever been to a chiropractor? Y/N If yes explain:_____

Signature Date

Dr. Cheryl Lee-Pow Cheryl.leepow@powherchiro.com

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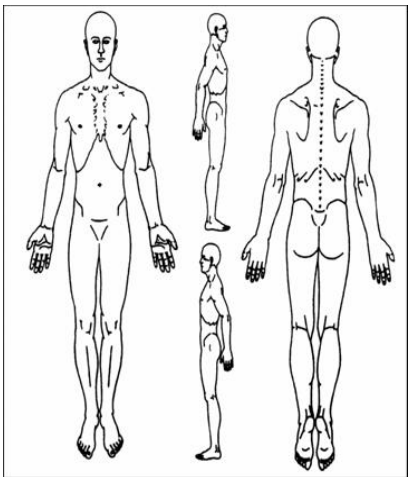
INJURY SURVEY



1. **Please outline the area(s) of your discomfort on the diagram.**
2. When did your symptoms begin: Month_____ Day_____ Year_____
3. Where did your symptoms begin? Home, Work, Accident_____
4. How did you hurt yourself:_____
5. What helps the pain feel better: Moving/Sit/Laying/Rest/Exercise/Nothing Other:_____Medications_____
6. What makes the pain worse: Sitting/Standing/Laying _____
7. Rate your overall pain on a scale 1-10 (0-well to 10-severe) morning____afternoon___evening ____overall_____

Please Circle Areas of Complaint:

Headaches	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	1-10
Neck Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Shoulder Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Arm	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Elbow	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Forearm	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Wrist	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Hand	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
Upper Back Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
Midback Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
Lower Back Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
Buttock Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Hip Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Thigh Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Knee Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Ankle Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Foot Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
Other:	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	

Quality of pain:	Ache/ Dull	Sharp	Shooting	Stabbing	Throbbing
	Numb/Tingling	Sore	Deep	Electric	Fiery

8. Have you ever had this before: Y/N When? _____
9. Have you seen anyone else for the pain: Date/Provider/Treatment_____
_____
10. Have you missed work due to the pain? _____ Have you lost sleep due to the pain?_____
11. Have you been limited in any activities due to this pain? _____
12. Do you exercise? ( )Yes ( )No Has your exercise been hindered by this injury? ( )Yes ( )No

    Type of Exercise:_____

Dr. Cheryl Lee-Pow Cheryl.leepow@powherchiro.com