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

CAR INSURANCE INFORMATION

[ ] No car Insurance

YOUR CAR INSURANCE

Insured Person: [ ] Self [ ] Other

(Other) Social Security #_____
Ins. Provider:_____
Your Claim # _____
** Contact person/adjuster:* _____
Phone # _____

[ ] No Health Insurance

YOUR HEALTH INSURANCE

Insured Person: [ ] Self [ ] Other
Social Security # _____
Plan Name:_____
Group # _____
Policy #_____

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	Neurologic	Eyes/Ears	Musculoskeletal	Nose	Mouth/Throat
Rash	Headache	Hearing trouble	Neck pain	Pain	Sores
Eczema	Dizziness	Ringing	Upper back pain	Bleeding	Bleeding
Itching	Fainting	Vision Trouble	Low back pain	Sinus Problems	Tonsilitis
Skin Changes	Convulsion	Pain	Upper extremity pain	Infections	Enlarged Glands
Redness	Nervousness	Discharge	Lower extremity pain	No Smell	No Taste
Bruise easily	Confusion		Jaw pain		Abnormal Taste
Hair changes	Numbness		General stiffness		Bad breath
	Paralysis		Walking problems		
	Cold/tingling extremities				

Heart Lungs	Breasts	Stomach/Digestion	Genitourinary	Endocrine	Psychological
Cough		Decreased Appetite	Inability hold urine		Anxiety
Wheezing	Lumps	Increased Appetite	Painful Urination	Thyroid	Depression
Asthma	Redness/Itching	Abdominal Pain	Frequent Urination	Heat/Cold intolerance	Phobia
Difficulty Breath	Pain	Hemorrhoids	Bedwetting	Sugar in urine	Mood Swings
Swollen UE/LE	Dimpling	Excess Gas	Irregular Menstruation	Goiter	ADD/ADHD
Blue UE/LE	Discharge	Vomit	Painful Menstruation	Tremor	Mental Disorders
Varicosities		Diarrhea	Abnormal Vaginal		
Murmur		Constipation	Bleeding		
Chest Pain			Prostate Problems		
Palpitations			Sterility		

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:_____

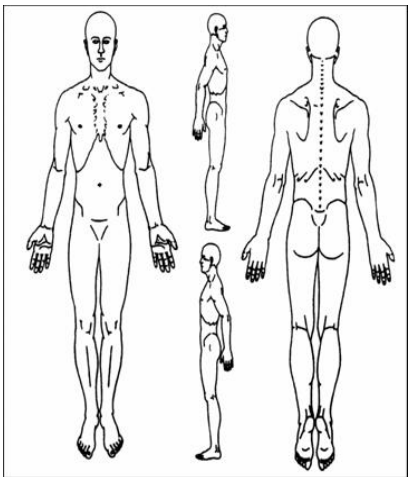
Grandparents:_____ Children:_____

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

Signature Date

Pow-Her Chiropractic 600 Jefferson Plaza Suite 350 Rockville MD 20852 www.powherchiro.com

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:_____