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- P*lease 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**

HealthQuest

Patient Name: ____________________ Acct#: ______________

REVIEW OF SYSTEMS

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days:

0 = Never have this symptom
1 = Occasionally have this symptom, but the effect is not severe
2 = Occasionally have this symptom, and the effect is severe
3 = Frequently have this symptom, but the effect is not severe
4 = Frequently have this symptom, and the effect is severe

Head: _______ Headaches _______ Faintness _______ Dizziness _______ Insomnia	**Energy/Activity:** ______ Fatigue/Sluggishness ______ Apapthy/Lethargy ______ Hyperactivity ______ Restlessness	**Lungs:** ______ Chest Congestion ______ Asthma, Bronchitis ______ Shortness Of Breath ______ Difficulty Breathing
Eyes: _____Watery or Itchy Eyes _____Swollen,Red or Sticky Eyelids _____Bags or Dark Circles Under Eyes _____Blurred or Tunnel Vision (not including near or far sightedness)	**Weight:** ______ Binge Eating/Drinking ______ Craving Certain Foods ______ Excessive Weight ______ Compulsive Eating ______ Water Retention ______ Underweight	**Heart:** ______ Irregular / Skipped Heartbeat ______ Rapid or Pounding Heartbeat ______ Chest Pain
Ears: ______ Itchy Ears ______ Earaches, Ear Infections ______ Drainage From Ear ______ Ringing In Ears, Hearing Loss	**Emotions:** ______ Mood Swings ______ Anxiety/Fear/Nervousness ______ Anger / Irritability / or Aggressiveness ______ Depression	**Digestive Tract:** _______ Nausea, Vomiting _______ Diarrhea _______ Constipation _______ Bloated Feeling _______ Belching, Passing Gas _______ Heartburn _______ Intestinal/Stomach Pain
Nose: ______ Stuffy Nose ______ Sinus Problems ______ Hay Fever ______ Sneezing Attacks ______ Excessive Mucus Formation	**Skin:** ______ Acne ______ Hives, Rashes, Dry Skin ______ Hair Loss ______ Flushing, Hot Flashes ______ Excessive Sweating	**Joints / Muscles:** ______ Pain or aches in joints ______ Arthritis ______ Stiffness/limited movement ______ Pain / aches in muscles ______ Feeling of weakness or tiredness
Mouth & Throat: ______ Chronic Coughing ______ Gagging, Frequent Need to Clear Throat ______ Sore Throat, Hoarseness ______ Swollen or Discolored Tongue, Gums or Lips ______ Canker Sores	**Mind:** ______ Poor Memory ______ Confusion / poor comprehension ______ Poor concentration ______ Poor physical condition ______ Difficulty in making decisions ______ Stuttering / stammering ______ Slurred speech ______ Learning disabilities	**Other:** _______ Frequent Illness _______ Frequent or Urgent Urination _______ Genital Itch or Discharge
		Grand Total:

HealthQuest

Patient Name: ______________________ Acct#: _______________

HISTORY of YOUR COMPLAINT

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

____

What other health complaints do you currently have (whether or not you think they are related to our office?

____

____

PLEASE DRAW your pain on the Diagram, and add the following **letters** to describe your symptoms:
R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/ Stabbing T= Tingling

When is the problem at its worst? ❑ AM ❑ PM ❑ mid-day ❑ late PM

How long does it last? ❑ constant ❑ on/off through day ❑ comes/goes all week

On a scale of 0-10 with **zero** being no pain and **10** being the worst pain imaginable ("Emergency Room"), rate your MAIN complaint when AT IT'S WORST: _______________

What relieves your symptoms? ____

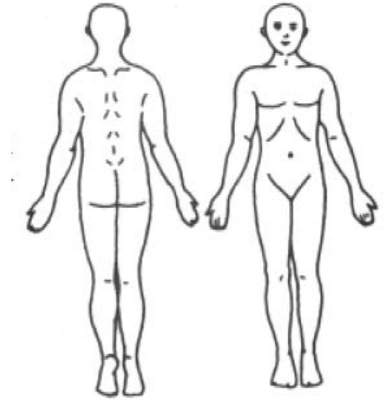
What makes them feel worse? ____

Does the pain radiate? ❑ Yes ❑ No (starts_______________ ends _______________)

When did main complaint begin? ____

How did your main complaint first come about? ______________________________

____



PAST HISTORY

Have you suffered with any of this or a similar complaint in the past? ❑ No ❑ Yes **If yes** how many times? ______________

When was the last episode? _______________ How did it happen?_________________________________

Is your complaint the result of an accident? ❑ No ❑ WORK related ❑ AUTOMOBILE wreck ❑ Personal Injury

❑ Other ____

PLEASE identify ANY PAST and **CURRENT** conditions, whether or not you think they are contributing to your *current complaint:*

Identify any other injury(s) to your spine, minor or major, that the doctor should know about: ___________________________

____

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

Any other surgeries (and dates)? ____

____

Occupation: _____________________________________ How long? __________________

Repetitive daily work duties or prolonged postures? (sitting, bending, etc): ______________________________

Other forms of treatment tried: ❑ No ❑ Yes If yes, what were the results? ❑ Favorable ❑ Unfavorable

❑ Anti-inflammatory meds (year _____) ❑ Muscle relaxer meds (year ______) ❑ Pain Meds (year _____)
❑ PT (year ______) ❑ Injections (year ______) ❑ Massage (year ______) ❑ Exercise (year ______)
❑ Chiropractic (year ______) Chiropractor's name and city: _____________________________

What is this complaint preventing you from doing? ____
If not completely preventing, even partially preventing or annoying when trying? _____________________________

____

The main complaint has been going on for _______ wks / mos / yrs.

What do you think will happen to this complaint without treatment? _________________________

Patient Name: ______________________ Acct#: _______________

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

Do you have any medication allergies? ❑ Yes (please fill in below) ❑ No

Medication Name	Reaction	Onset Date

SOCIAL HISTORY

Smoking: ❑ Never smoked ❑ Former smoker (quit date: ______) ❑ cigarettes ❑cigars ❑ pipe ❑ vaping
❑ Current Occasional smoker ❑ Current daily smoker (___ packs/day) year started ________

Other Tobacco Products: ❑ smokeless tobacco / dip ❑ chewing tobacco

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

Recreational Drug use: ❑ No ❑ Yes (list drugs used) ____
If yes, How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

How does your present complaint affect the following: Hobbies -Recreational Activities- Exercise Regime:

____

FAMILY HISTORY:

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

❑ heart disease (who _____________) ❑ stroke (who ___________) ❑ cancer (who ___________)

❑ high blood pressure (who ___________) ❑ arthritis (who ___________) ❑ obesity (who ___________)

❑ diabetes (who ___________) ❑ osteoporosis (who ___________) ❑ scoliosis (who ___________)

❑ thyroid conditions (who ___________) ❑ other ______________________

Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know

If yes, what was the outcome? ____

Any other hereditary conditions of which the doctor should be aware? ❑ No ❑Yes: ____________________

PREVIOUS DIAGNOSTIC STUDIES: (please list ALL STUDIES performed on you)

MRI / X-Ray / CT Scan /Etc	Part of Body Studied?	Doctor Who Ordered Test?	Name of Imaging Center? (Mayfield, Proscan, Etc)	Date Performed

Primary Care Physician's name, address and phone #?: OK to share your health exam info with your Doctor? ❑ Yes ❑ No

____

❑I choose to decline receipt of my clinical summary after every visit (Our office uses Electronic health records. We produce daily clinical summaries, which are often blank as a result of the nature and frequency of Chiropractic care.)

______________________________ ______________________________

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