

Welcome

Registration Form

PATIENT INFORMATION

Last Name, First Name MI		Title		Preferred Name	
Date of Birth	Age	Gender	Marital Status	Spouse/Parent Name	
Street Address			City	State	Zip
Mailing Address (if different)			City	State	Zip
SSN	Home Number		Cell Number	Work Number	
Email (for private use by this office only)			Employer	Occupation	
Whom may we thank for referring us to you?			Other family members seen here		

EMERGENCY CONTACT

Name of local friend or relative (not living with you)	Home Phone	Cell Phone
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INSURANCE INFORMATION

Person responsible for bill		Is this person a patient here?			
Primary subscriber name		Date of birth			
Primary Insurance	Phone	ID/SSN # of subscriber	Group #		
Secondary subscriber name		Date of birth			
Secondary Insurance	Phone	ID/SSN of subscriber	Group #		



Dr. Goff's
Chiropractic & Wellness

CHIROPRACTIC HISTORY

List your problems or complaints, according to severity of pain	Rate your pain, 10 being the worst.	Date started or For how long.
1	1 2 3 4 5 6 7 8 9 10	
2	1 2 3 4 5 6 7 8 9 10	
3	1 2 3 4 5 6 7 8 9 10	

Please answer the following in regards to problem/complain #1 above:

How would you describe the pain? Sharp Dull Diffuse Achy
 Burning Shooting Stiff Numb Tingly Sharp with motion
 Shooting with motion Stabbing with motion Electric like with motion

Is the problem: getting worse? staying the same? getting better?

How often do you experience your symptoms? Constantly 76-100% Frequently 15-76% Occasionally 26-50% Intermittently 1-25%

How much has the problem interfered with your normal activities? Not at all A little bit
 Moderately Quite a bit Extremely

How much has the problem interfered with your work/required tasks? Not at all A little bit
 Moderately Quite a bit Extremely

Do you consider your problem to be severe? Yes Yes, at times No

What aggravates your problem? _____

What makes your problem feel better? _____

What concerns you the most about your problem; what does it prevent you from doing? _____

Who else have you seen for your problem? Chiropractor Neurologist Primary Care Physician
 ER Physician Orthopedist Massage Therapist Physical Therapist
 No one Other: _____

What activities do you do at work?
 Sit: Most of the day Half of the day A little of the day
 Stand: Most of the day Half of the day A little of the day
 Computer Work: Most of the day Half of the day A little of the day
 On the phone: Most of the day Half of the day A little of the day

What activities do you do outside of work? _____

Anything else we should know? _____

How would you rate your overall health? Excellent Very Good Fair Poor

What type of exercise do you do? Strenuous Moderate Light None

Have you seen chiropractor before? _____ If yes, when was your last adjustment? _____

What were the results? Great Good Fair Poor

HEALTH HISTORY

How many alcoholic drinks do you consume per **week**? _____ How many caffeinated drinks do you consume per **day**? _____
 How many times do you eat out per **week**? _____ How many times a **week** do you eat raw nuts or seeds? _____
 How many times a **week** do you eat fish? _____ How many times a **week** do you workout? _____
 List the **three worst foods** you eat during the **average week**? _____
 List the **three healthiest foods** you eat during the **average week**? _____
 Do you smoke? _____ If yes, how many times a **day**, _____ a **week**? _____
 Rate your stress levels on a scale of 1-10 during the week _____

Please list the 5 **major HEALTH concerns** in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Past	Present		Past	Present	Past	Present		
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stone	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Change	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite			_____
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain			_____
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer			_____
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis			
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disorder			For Females Only
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy

List all the prescription medications you are currently taking: _____

List all the vitamins/supplements you are currently taking: _____

List all the surgical procedures you have had: _____

CERTIFICATION

To the best of my knowledge, the previous information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health and/or insurance coverage

Printed Name of PATIENT

Signature of PATIENT or PARENT/GUARDIAN

Date

CONSENT TO TREAT A MINOR

(If applicable)

Back & Body Chiropractic has my permission to render any medically necessary services to my child

Printed Name of PATIENT

Signature of PARENT/GUARDIAN

Date

PATIENT FINANCIAL POLICY

This office had adopted a financial policy that is outlined. If you have any questions regarding this policy, please discuss them with our office manager.

- Unless other arrangements have been made in advance by either you or your insurance carrier, full payment is due at the time of services are rendered.

Your Insurance

- We have made prior arrangements with many insurance carriers to accept assignment of benefits. This means that we will bill those plans for which we have an arrangement and will only require you to pay the authorized co-payment at the time of service. It is the policy of our office to collect this co-payment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have prior arrangement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer may send the payment directly to you. Consequently, the charges for your care and treatment may be due at the time of service.

In the event that your health plan determines a service to be not covered, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, responsibility will fall to the adult accompanying the patient or the parent or guardian with custody for payment.

I hereby authorize Dr. Jonathan Goff to use other diagnostic aids to make a thorough diagnosis of my chiropractic needs. I have answered all questions concerning my medical health history to the best of my knowledge.

- I authorize the release of my medical records to secure payment of insurance benefits.
- I authorize my insurance company to assign benefits to *Dr. Goff's Chiropractic & Wellness* for payment of services rendered.
- I authorize the use of this signature on all insurance submissions.
- I have read the copy of the privacy policy information and will/have reviewed the information.

Please note that a cancellation fee will be charged unless notice is given 24 hours prior to a scheduled appointment.

A \$25.00 fee will be charged for any returned check plus any recovery fees that may be incurred.

I have read and understand the Financial Policy, Signature Authorization, and Privacy Policy, and I agree to its terms and definitions. I also understand and agree that such terms may be amended from time to time by the practice.

Printed Name of PATIENT

Signature of PATIENT or PARENT/GUARDIAN

Date