

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
--	------------	------------

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 #		



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. _____

How long have you suffered with this/these problem(s)? _____

Any other complaints? _____

Would you like improvements with any of the following?

- Digestion: Reflux, Gas Constipation Sleep: Falling asleep or staying asleep Sense of Well Being Energy

What have you tried doing to resolve this problem? _____

Have you become discouraged or stressed about handling this problem? _____

When your problem is at its worst, how does it make you feel? _____

How does this problem interfere with the following areas of your life?

Work: _____
Family: _____
Hobbies: _____
Life: _____

When it's at its worst, how much older does this make you feel? _____

Do you know how this problem may have started? _____

What effect does this have on your body functions? _____

Are you visiting us to:

- Resolve my immediate problem
- Lifestyle program for optimizing living
- Both
- Other: _____

How have you taken care of your health in the past? (please check all that apply)

- Medication
- Routine Medical
- Exercise
- Diet and Nutrition
- Holistic
- Vitamins
- Chiropractic
- Other: _____

How did previous methods work for you? _____

What are you afraid this might be or will be affecting without change? (please check all that apply)

- Job
- Kids
- Marriage/Relationship
- Sleep
- Freedom
- Future abilities
- Finances
- Time

Are there any health conditions you are afraid this might turn into? (please check all that apply)

- Diminished future abilities
- Stress
- Weight gain
- Heart disease
- Depression
- Surgery
- Arthritis
- Cancer
- Diabetes
- Other: _____

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of?

Please be specific: _____

What would be different or better without this problem? (check all that apply)

- Diminished stress
- More energy
- Self esteem
- Confidence
- Sleep
- Work
- Outlook
- Family

If we were able to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short! Include anything that is part of your happiness, weather health, family, work, finances, travel, marriage or bucket list.)

What potential barriers do you foresee that would prevent these things from happening? _____

Do you feel it is possible to eliminate or prevent these potential barriers? _____

What are your strengths that will enable you to accomplish your goals? _____

METABOLIC ASSESSMENT

Please circle the appropriate number **0–3** on all questions below.

0 as the least/never to 3 as the most/always

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard dry or small stool	0	1	2	3
Coated tongue of “fuzzy” debris on tongue	0	1	2	3
Pass large amounts of foul smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars or starches	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotions, detergents, etc.	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning or aching 1-4 hours after eating	0	1	2	3
Do you frequently use antacids	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0	1	2	3

Category VI

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool digested, foul smelling. Mucous-like greasy or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Lowered gastrointestinal motility, constipation	0	1	2	3
Raised gastrointestinal motility, diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3

Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome or Leaky Gut Syndrome?	Yes	No
--	-----	----

Category VIII

Greasy or high fat foods cause distress	0	1	2	3
Lower bowel gas and/ or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History or gallbladder attacks or stones	0	1	2	3
Have you had gallbladder removed	Yes	No		

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Felling shaky, jittery. Tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meal	0	1	2	3
Crave sweets during day	0	1	2	3
Eating sweets does not relieve craving for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII:

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Leg nervousness at night 0 1 2 3

Category XIV

Edema and swelling in ankles and wrists 0 1 2 3
Muscle cramping 0 1 2 3
Poor muscle endurance 0 1 2 3
Frequent urination 0 1 2 3
Frequent thirst 0 1 2 3
Crave salt 0 1 2 3
Abnormal sweating minimal activity 0 1 2 3
Alteration in bowel regularity 0 1 2 3
Inability to hold breath for long periods 0 1 2 3
Shallow, rapid breathing 0 1 2 3

Category XV

Tires, sluggish 0 1 2 3
Feel cold - hands, feet, all over 0 1 2 3
Require excessive amounts of sleep to function properly 0 1 2 3
Increased weight gain even with low-calorie diet 0 1 2 3
Gain weight easily 0 1 2 3
Difficult, infrequent bowel movements 0 1 2 3
Depression, lack of motivation 0 1 2 3
Morning headaches that wear off as the day progresses 0 1 2 3
Outer third of eyebrows thins 1 2 3
Thinning of hair on scalp, face, genitals or excessive hair loss 0 1 2 3
Dryness of skin and/or scalp 0 1 2 3
Mental sluggishness 0 1 2 3

Category XVI

Heart palpitations 0 1 2 3
Inward trembling 0 1 2 3
Increased pulse even at rest 0 1 2 3
Nervous and emotional 0 1 2 3
Insomnia 0 1 2 3
Night sweats 0 1 2 3
Difficulty gaining weight 0 1 2 3

Category XVII (MALES only)

Urination difficulty or dribbling 0 1 2 3
Urination frequent 0 1 2 3
Pain inside of legs or heels 0 1 2 3
Feeling of incomplete bowel evacuation 0 1 2 3

Category XVIII (MALES only)

Decrease in libido 0 1 2 3
Decrease in spontaneous morning erections 0 1 2 3
Decrease in fullness of erections 0 1 2 3
Difficulty in maintaining morning erections 0 1 2 3
Spells of mental fatigue 0 1 2 3
Inability to concentrate 0 1 2 3
Episodes of depression 0 1 2 3
Muscle soreness 0 1 2 3
Decrease in physical stamina 0 1 2 3
Unexplained weight gain 0 1 2 3
Increased in fat distribution around chest and hips 0 1 2 3
Sweating attacks 0 1 2 3
More emotional than in the past 0 1 2 3

Category XIX (Menstruating FEMALES only)

Perimenopausal Yes No
Alternating menstrual cycle lengths Yes No
Extended menstrual cycle (greater than 32 days) Yes No
Shortened menses (less than 24 days) Yes No
Pain and cramping during periods 0 1 2 3
Scanty blood flow 0 1 2 3
Heavy blood flow 0 1 2 3
Breast pain and swelling during menses 0 1 2 3
Pelvic pain during menses 0 1 2 3
Irritable and depressed during menses 0 1 2 3
Acne 0 1 2 3
Facial hair growth 0 1 2 3
Hair loss/thinning 0 1 2 3

Category XX (Menopausal FEMALES only)

How many years have you been menopausal? years
Do you ever have uterine bleeding since menopause? Yes No
Hot Flashes 0 1 2 3
Mental foginess 0 1 2 3
Disinterest in sex 0 1 2 3
Mood swings 0 1 2 3
Depression 0 1 2 3
Painful intercourse 0 1 2 3
Shrinking breasts 0 1 2 3
Facial hair growth 0 1 2 3
Acne 0 1 2 3
Increased vaginal pain, dryness or itching 0 1 2 3

Please list any medication you currently take and for what conditions: _____

Please list any natural supplement you currently take and for what conditions? _____

Rate on a scale of 1-10 (10 being the most likely and 1 being the least likely).

- _____ How important is it for you to resolve your health concerns
_____ Do you feel that you are coachable and would enjoy a mentor in helping you?
_____ Are you prepared to make appropriate lifestyle changes that may be necessary in order to achieve your goals?

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



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

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