T-TOWN CHIROPRACTIC
REGISTRATION FORM

Date_____ Home Phone _____ Cell Phone _____

Email _____

Last Name _____ First Name _____ Middle Initial _____

Street Address _____

City_____ State _____ Zip _____

Sex: ☐ M ☐ F Age _____ Birth date _____ Occupation _____

Are you: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Spouse Name (If applicable) _____

Who referred you to this office? _____

PARENTAL CONSENT TO EVALUATE AND TREAT A MINOR

I _____, being the parent/legal guardian of _____
hereby grant permission for my child to receive chiropractic care.
Witness _____

CONSENT TO INITIATE CARE

At our office, we have one simple goal – we want to render the highest quality Chiropractic care at the lowest possible fee. In order to accomplish this goal, we have altered some of our business procedures to keep our fees reduced. Please read over these procedures below to understand how our office functions, and to decide if you wish to participate. If you have any questions, please direct them to the receptionist.

- You may choose to submit receipts to your insurance company or other third-party health care programs, but payment for such services by insurance companies is neither implied nor agreed to by this office. We take ***no responsibility*** for non-payment by insurance companies for services rendered at our office.
- Our office will not respond to any requests for paperwork for insurance purposes or even acknowledge insurance requests for information on any patient's case. However, patients may have a copy of their records.
- No balances can be kept or run by patients at any time.
- All adjustment visits are paid immediately ***prior*** to the service being rendered.
- All initial visits are paid for upon *completion* of these services.
- Our office reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served.

I wish to initiate care at this office. I have read and understand the Consent to Initiate Care and agree to all terms. I understand that I am under no obligation to receive or continue care.

Print your name _____ Today's Date _____

Sign your name _____

SOME QUESTIONS TO HELP US HELP YOU

NAME: _____ DATE: _____

If you could only help with one health problem, what would that be?

_____

_____

What other health problems would you like us to help you with?

_____

_____

How did these problems start?

_____

_____

When did these problems begin? _____

Have you ever had these problems before? _____

Is it worse in the morning or at night (check one)? Morning _____ or Night _____

Do you have numbness, tingling or pain in the arms or legs? _____

How often do you feel the pain and how long does it last? _____

Please list any doctors seen for the above problem: _____

Please list medications you are currently taking: _____

Please list any surgeries you have had: _____

Please list any auto or work accidents you have had: _____

Please (circle) any in your family history: Heart Disease - Diabetes - Arthritis - Cancer - Back Problems

Do you get any dizziness (circle one)? Yes / No Do you have heart, lung or stomach problems (circle one)? Yes / No

Are you right or left-handed? _____ How tall are you? _____ How little do you weigh? _____

Name of previous chiropractor: _____

When were the last x-rays of your spine taken? _____

(Check only one)

Are you looking for temporary relief (Band-Aid care: 1-3 visits) ☐

Or do you want the cause of your problem fully corrected (Getting to the Root of the Issue) ☐

Why? _____

_____

What activities or hobbies have you been unable to do because of your problem?

_____

_____

MUSCULO-SKELETAL SYSTEM

____ Low back problems
____ Pain between shoulders
____ Neck problems
____ Arm problems
____ Leg problems
____ Swollen joints
____ Painful joints
____ Stiff joints
____ Sore muscles
____ Weak muscles
____ Walking problems
____ Ruptures
____ Broken bones

GENITO-URINARY SYSTEM

____ Bladder trouble
____ Excessive urination
____ Scanty urination
____ Painful urination
____ Discolored urine

FEMALE

____ Vaginal discharge
____ Vaginal bleeding
____ Vaginal pain
____ Breast pain
____ Lumps on breast

Are you pregnant?
____ Yes ____ No

GASTRO-INTESTINAL SYSTEM

____ Poor appetite
____ Excessive hunger
____ Difficult chewing
____ Difficult swallowing
____ Excessive thirst
____ Nausea
____ Vomiting food
____ Vomiting blood
____ Abdominal pain
____ Diarrhea
____ Constipation
____ Black stool
____ Bloody stool
____ Hemorrhoids
____ Liver trouble
____ Gall bladder problems
____ Weight trouble

NERVOUS SYSTEM

____ Numbness
____ Loss of feeling
____ Paralysis
____ Dizziness
____ Fainting
____ Headaches
____ Muscle jerking
____ Convulsions
____ Forgetfulness
____ Confusion
____ Depression

CARDIO-VASCULAR-RESPIRATORY

____ Chest pain
____ Pain over heart
____ Difficult breathing
____ Persistent cough
____ Coughing phlegm
____ Coughing blood
____ Rapid heartbeat
____ Blood pressure problem
____ Heart problems
____ Lung problems
____ Varicose veins

EYE, EARS, NOSE, THROAT

____ Eye strain
____ Eye inflammation
____ Vision problems
____ Ear pain
____ Ear noises
____ Hearing loss
____ Ear discharge
____ Nose pain
____ Nose bleeding
____ Nose discharge
____ Difficult breathing through nose
____ Sore gums
____ Dental problems
____ Sore mouth
____ Sore throat
____ Hoarseness
____ Difficult speech

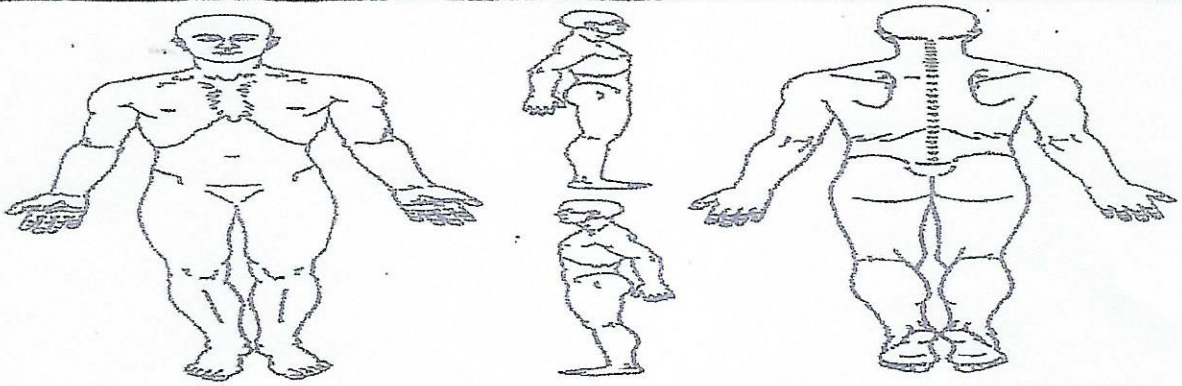
Signed: _____

(Please Print Name): _____

Date: _____

Mark the areas on your body where you feel pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol (s) listed below.

Ache >>>>>>	Numbness ======	Pins and Needles ↓↓↓↓↓↓	Burning xxxxxx
Stabbing ▽▽▽▽▽	Throbbing ~~~~~~	Tingling +++++	Sharp ↔↔↔↔
Dull 0 0 0 0 0	Soreness ∩∩∩∩∩	Shooting ⊕ ⊕⊕ ⊕	Other



On a pain analog scale of 0 to 10, with 0 being the absence of pain and 10 being significant enough to seek emergency care, which numbe would describe your pain/discomfort severity, please circle.

What is your pain/discomfort like today?	No Pain -0-1-2-3-4-5-6-7-8-9-10	Severe Pain
What is your least pain/discomfort?	No Pain -0-1-2-3-4-5-6-7-8-9-10	Severe Pain
What is your worst pain/discomfort?	No Pain -0-1-2-3-4-5-6-7-8-9-10	Severe Pain