REGISTRATION OF INFORMATION

Date: ______________________________

PLEASE PRINT

(Please circle one) Dr., Mr., Mrs., Ms., Miss Home Phone: (____) ____________________

First Name: ____________________ MI: ____ Last Name: ____________________ Social Security #: ______________

Street Address: ________________________________ City ________________________ State: ____ Zip: __________

Sex: M F Date of Birth: ________________ Age: ____ Marital Status: Single Married Divorced Widowed Separated

Children: ______________ Education Level obtained: ______________ Referred to our office by: ______________

Spouse's Name: ______________________________ Spouse's Occupation: ______________________________

Primary Care Physician (name, address & telephone): ______________________________

Employer and Employer's Address: ______________________________

Work Phone: (____) ________________________ Occupation: ______________________________

Student Status: Full Time Part Time Name of School: ______________________________

If you are the responsible party, mark "self" and move down to "Insurance Information".

Patient's relationship to responsible party: Self Spouse Dependent

First Name: ____________________ MI: ____ Last Name: ____________________ Social Security #: ______________

Street Address: ________________________________ City ________________________ State: ____ Zip: __________

Sex: M F Date of Birth: ________________ Age: ____ Marital Status: Single Married Divorced Widowed Separated

Employer and Employer's Address: ______________________________

Work Phone: (____) ________________________ Occupation: ______________________________

INSURANCE INFORMATION

Insurance Company: ______________________________ Insurance Company's telephone #: (____) ______________

Insurance Company's Address: ______________________________

Group or Policy Number: ______________________________ Subscriber or I.D. #: ______________________________

Secondary Insurance: ______________________________ Insurance Company's telephone #: (____) ______________

Insurance Company's Address: ______________________________

Group or Policy Number: ______________________________ Subscriber or I.D. #: ______________________________

RELEASE AND ASSIGNMENT

1. I authorize the release of any medical information necessary to process my insurance claim(s)
2. I authorize and request payment of medical benefits directly to Wano Chiropractic Weight Loss & Nutrition Centers, Inc.
3. I agree that this authorization will cover all medical services rendered until such authorization is revoked in writing by me.
4. I agree that a photocopy of this form may be used in lieu of the original.
5. I hereby consent to any procedures or treatment for my condition as deemed necessary by the attending doctors

______________________________ ____/____/____

Signed (patient or representative) Date

____

Patient's Name (Printed)

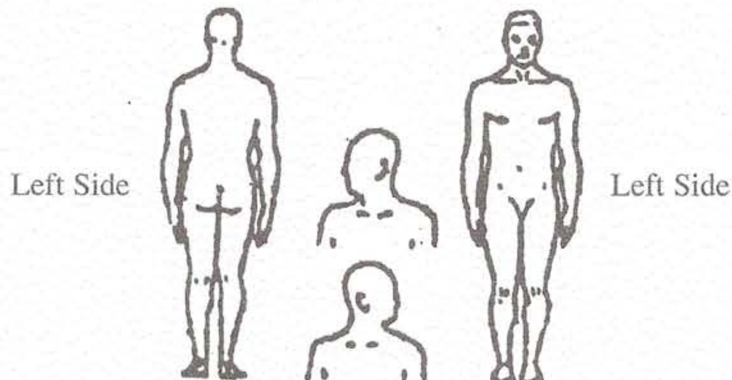
ATTENTION: Payment is to be made at the time of the visit unless prior arrangements have been made with this office. Also 24-HOUR NOTICE is necessary to cancel an appointment, and you may be responsible for payment of a missed appointment

MEDICAL HISTORY

Name: Date:

MAIN COMPLAINT: Why are you here today? Be specific with location: ____

1. When did it start? Date: ____
2. How did it start? Explain: ____
3. Recent work-related injury? Y N • Recent auto accident? Y N • Injury at home? Y N • Injury elsewhere Y N
4. Does it radiate to any other part of your body? Y N Where? ____
5. Did it begin gradually or suddenly? ____
6. How would you describe the intensity? (mild, moderate, severe) ____
7. Describe your pain (dull, sharp, burning, numbness, soreness, stiffness): other: ____
8. Has your problem been getting worse, better, or about the same? ____
9. Does your condition come and go or is it all the time? ____
10. What makes your symptoms better? ____
11. What makes your symptoms worse? ____
12. Have you tried home remedies? Y N Details ____
13. What doctors have you seen and what tests have been done for your condition? ____
14. Have you had anything like this before? Y N What? ____
15. Have there been any other changes in any body functions? Y N Details: ____
16. Has your condition affected your daily activities in any way? Y N Explain: ____
17. Have you been unable to work as a result of your current problem? ____
18. Do you have any other problems that you would like the doctors to evaluate? ____



PAST HISTORY

1. Have you had any of the following diseases: (Circle) Measles, Rubella, Chickenpox, Mumps, Scarlet Fever, Rheumatic Fever, Tuberculosis, HIV, Hepatitis, Other: ______
2. Have you been diagnosed with any other conditions? Y N Explain: ______
3. Are you under a doctor's care presently for any type of health problem? ______
4. Have you had any broken bones? Y N Which ones? ______
5. Have you ever had any past significant auto accidents, work injuries or falls? Y N When? ______
6. Are you taking any medications? Please list. ______
7. Have you ever undergone any type of surgery? What and when? ______
8. Do you smoke, drink alcohol or use recreational drugs? ______
9. Do you have any allergies? ______
10. Do any diseases run in the family? ______

SYSTEM REVIEW

HAVE YOU BEEN DIAGNOSED OR BEEN TOLD YOU HAVE THE FOLLOWING?

Y N High blood pressure
Y N Hardening of the arteries
Y N Diabetes
Y N Heart or blood vessel disease
Y N Bone spurs on the neck (cervical spondylosis)
Y N Whiplash injury
Y N Have any of your relatives ever suffered a stroke?
Y N Blurred vision
Y N Double vision
Y N Diminished or partial loss of vision in one or both eyes
Y N Complete loss of vision in one or both eyes
Y N Sudden collapse without loss of consciousness
Y N Hearing loss in one or both ears
Y N Slurred speech or other speech problems
Y N Difficulty swallowing
Y N Dizziness
Y N Temporary lack of understanding
Y N Loss of consciousness, even momentary blackouts
Y N Numbnesss or loss of sensation in the face, arms, hands, fingers, or legs
Y N Any other abnormal or loss of sensation in any other part of the body
Y N Weakness, clumsinesss, or strength loss in the face, arms, hands, fingers, or legs
Y N Ringing, buzzing, or any noise in the ears

WOMEN ONLY

Do you experience any of the following symptoms?

Y N Do you take birth control pills? How long? ______
Y N Menstrual pain
Y N Cramping
Y N Irregularity
Y N Date of last period ______
Y N Are you now pregnant? _____ How long? ______

MEN ONLY

Date of last prostate exam: ______
Difficulty with urination? Y N Explain ______
Excessive urination? Y N Explain ______