BACKCARE FAMILY CHIROPRACTIC, LLC

REGISTRATION AND HISTORY

ACCIDENT INFORMATION Pt Name _____ Acct_____

Is condition due to an accident? [ ] Yes [ ] No Date _____ Type? [ ] Auto [ ] Work [ ] Home [ ] Other

To whom have you made a report ? [ ] Auto Ins [ ] Employer [ ] Workers Comp [ ] Other

Claim Number Ins Phone Number Attorney Name

HEALTH HISTORY

Have you received any of the following treatments for your condition?

[ ]Medication [ ]Surgery [ ]Physical Therapy [ ]Chiropractic [ ]None [ ]Other:_____

Name and address of other doctor(s) who have treated your condition _____

_____

Date of Last : Physical Exam _____ Spinal X-Ray _____ Blood Test _____ Spinal Exam _____

Chest X-Ray _____ Urine Test _____ Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Please write a **"Y"** to indicate if you have had any of the following :

AIDS/HIV		Hepatitis		Pinched Nerve	
Appendicitis		Hernia		Pneumonia	
Arthritis		Herniated Disc		Polio	
Asthma		Herpes		Prosthesis	
Bleeding Disorders		High Cholesterol		Psychiatric Care	
Bronchitis		Kidney Disease		Rheumatoid Arthritis	
Cancer		Liver Disease		Stroke	
Diabetes		Migraines		Thyroid Problems	
Emphysema		Miscarriage		Tonsillitis	
Epilepsy		Multiple Sclerosis		Tuberculosis	
Fractures		Osteoporosis		Tumors, Growths	
Gout		Pacemaker		Typhoid Fever	
Heart Disease		Parkinson's		Ulcers	
				Metal,Mechanical,Electrical Implants	
				Other:	

Exercise

[ ]None [ ]Moderate

[ ]Light [ ]Heavy

Work Activity

[ ]Sitting [ ]Standing

[ ]Light Labor [ ]Heavy Labor

Habits

[ ]Smoking Packs/Day ____ [ ]Coffee/Caffeine Cups/Day ____

[ ]Alcohol Drinks/Week ____

Are you pregnant? [ ] Yes [ ]No Due Date _____

Head Injuries _____

Broken Bones/ Dislocations _____

Illness/Disease _____

Surgeries _____

Other _____

Medications	Allergies	Vitamins/Herbs/Minerals

Pharmacy Name _____ Pharmacy Phone _____