File # :_____

PATIENT REGISTRATION

CONNELL CHIROPRACTIC CLINIC,, 20 TOWNLEE LN STE C, LUGOFF SC 29078, 803-408-9971 FAX 803-408-9973

HOW DID YOU HEAR ABOUT OUR CLINIC?

A Friend:_____; Doctor referral:_____; Other_____; Facebook; Google.

PATIENT INFORMATION

Name:_____Which name do you prefer to be called?_____

Address:_____City:_____State:____Zip:_____

(Please have Drivers License ready to be copied as your file ID)

E-Mail:_____

Home:_____ Cell:_____

Birth Date:_____ Age:_____ Sex: M / F

Emergency Contact:_____Home:_____Cell:_____

Marital Status: Single Married Widow Divorced Separated Are you a student? Yes No FT / PT
Employment Status: FT / PT / Retired Employer:_____Phone:_____
Occupation:_____
Doctor/Pediatrician:_____

PAYMENT DUE AT TIME OF SERVICE:

Copay/Coinsurance or Full amount due: CASH CHECK CREDIT CARD

I understand that **I will pay the balance of the account as services are rendered.**

SIGNATURE:_____Date:_____

Insurance Company: _____(Have Insurance Card ready for a copy to be made)
If you are a dependent on the insurance policy include: Spouse (or parent):_____
Birth Date:_____Employer:_____ Phone:_____

INSURANCE:

Once insurance plan benefits have been confirmed we will file with your insurance company. If we can not confirm chiropractic coverage or we are not in network with your plan, I agree to be set up as a cash patient. **Initial_____**

I, the undersigned certify, that I (and/or my dependents) have insurance with the company named above and assign directly to Connell Chiropractic Clinic, LLC, all insurance benefits, if any, otherwise payable for services rendered. I understand that I will pay for all charges for services whether or not paid by the insurance company. I hereby authorize the doctor to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature for all insurance submissions.

SIGN:_____Date:_____
Witness_____Date:_____

DISCLOSURE STATEMENT:

Chiropractic examination and therapeutic procedures (including spinal adjustment,ultrasound, heat/ice, manual muscle therapy, traction, non-surgical spinal decompression, electrotherapy and stretching) are considered safe and effective methods of treatment. Occasionally, however, a procedure intended to help may have complications. While the chances of complications are small, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, dizziness and temporary worsening of symptoms. More serious complications such as soft tissue injury, burns and bone injury are extremely rare. Additional information is available upon request. **I HAVE READ AND UNDERSTAND THESE STATEMENTS REGARDING TREATMENT SIDE-EFFECTS. I AUTHORIZE EXAM AND TREATMENT KNOWING THESE SIDE EFFECTS.**

Initial:_____

CURRENT PROBLEM...

Connell Chiropractic Clinic, Lugoff, SC

File: _____

NAME: _____ **Age:** _____

What is the Problem: _____

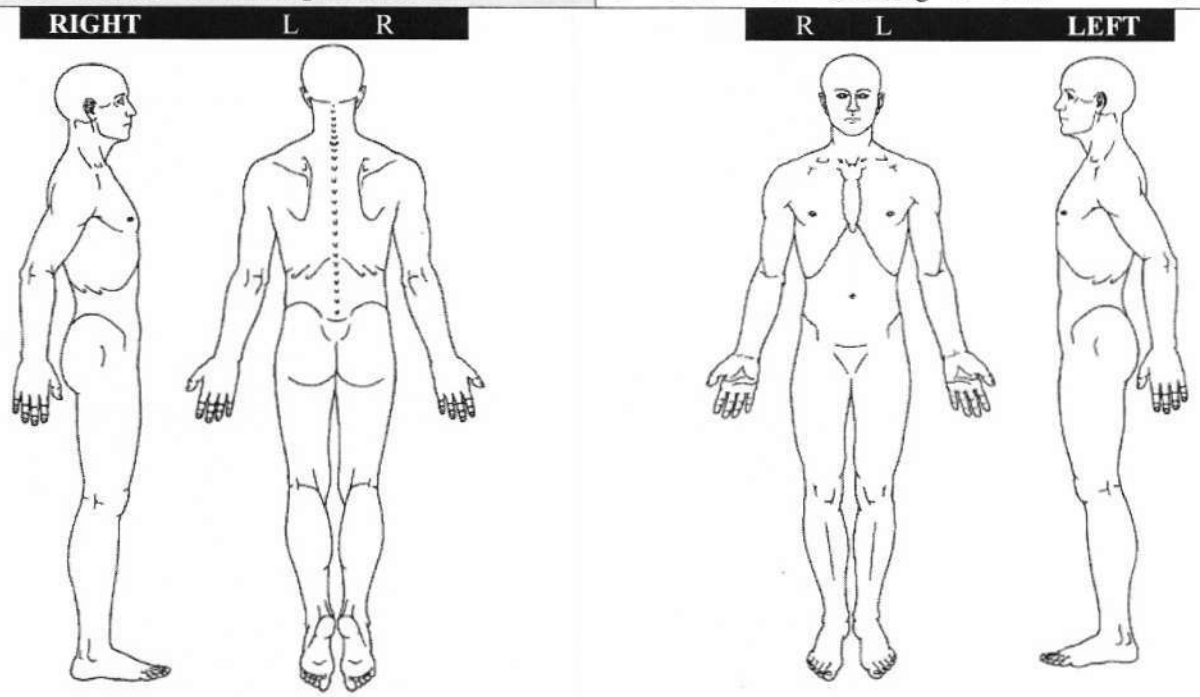
Fill in the BLANKS and CIRCLE all that apply to this problem.

When did it start?	1 2 3 4 5 6 7 8 9 10 11 12 / Several Day(s)/ Week(s)/ Month(s)/ Year(s) ago.	**What happened?**	
Did you go to: N/A	MD/ ER-Doc/ Name:	**The Diagnosis: N/A**	
Treated with: N/A **OR-- Self Treated:**	Oral Steroids, Steroid shot --- OR --- Ibuprofen/ Aleve/ Ice/ Heat/ Rest/ Massage	**Problem is:**	Staying the Same/ Getting Worse/ Improving/ Getting better/ Bad ALL day long
Pain Intensity: **10 = Worst Pain Ever**	**Now:** 1 2 3 4 5 6 7 8 9 10 **At Rest:** 1 2 3 4 5 6 7 8 9 10 **Moving Around:** 1 2 3 4 5 6 7 8 9 10	**Pain Intensity:** **10 =Worst Pain Ever**	**Morning:** 1 2 3 4 5 6 7 8 9 10 **Evening:** 1 2 3 4 5 6 7 8 9 10 **Sleep/Bed:** 1 2 3 4 5 6 7 8 9 10
Pain is:	Sharp/ Dull/ Throbbing/ Numb/ Tingling/ Aching/ Stabbing/ Shooting/ Burning/ Stiff/ Cramping/ Swelling/ Tight/ Bone ache/ Nagging	**These make it WORSE:**	Activity/ Sitting/ Driving/ Turning in bed/ Heat/ Standing/ Getting up from sitting/ Sitting up from lying.
Pain Duration is:	Intermittent/ On and Off/ Constant/ Unrelenting/ Never stops/ Wakes me up.	**These things have _ Helped: N/A**	Ibuprofen/ Aleve/ Tyleol/ Rest/ Ice/ Heat/ Massage/ Hot Shower/ Sleep/ Nothing
Pain Radiates: Y/N	R/ L/ Neck/ Lower/ Back/ Shoulder/ Blade/ Arm/ Hand/ Hip/ Knee/ Leg/ Foot	**Weakness? Y/ N**	Right/ Left/ Neck/ Back/ Shoulder/ Blade/ Arm/ Hand/ Hip/ Knee/ Leg/ Foot

Date of last: Physical exam_____ Spinal x-ray_____ Blood test_____

MRI _____ CT-scan _____ Bone Density_____

Circle the **location(s)** of your current symptoms. **Place the corresponding letter(s) to show the TYPE of pain at the Circled locations on the diagram below.**	**D** = Dull	**T** = Tingling	**AS** = Ache/Sore	**TP** = Throbbing
	SP = Sharp	**N** = Numb	**B** = Burning	**W** = Weak
	C = Cold	**ST** = Stabbing	**S** = Stiff	**P** = Pins/Needles



I certify that the information provided above is correct to the best of my knowledge. I will not hold the doctor or his staff responsible for any errors or omissions made in the completion of this form.

Patient Signature _____ Date:_____ Dr. Reviewed: _____

HEALTH QUESTIONNAIRE Connell Chiropractic Clinic, Lugoff, SC

File:_____

NAME: _____ Age: _____

Your **Occupation**_____

(Describe activities - sitting, lifting, etc.)

Coffee: Y/N ____/Cups/day	Smoker: Y/N ____/Packs/day	Alcohol: Y/N ____ /day/week	Rec. Drugs: Y/N ____/day/week

GENERAL SYMPTOMS **Check symptoms you have been dealing with in the past year.**

General
- ☐ Bruise easily
- ☐ Chills
- ☐ Dental problems
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Tiredness
- ☐ Weight gain

Genito-Urinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

Eye,Ear,Nose,Throat
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - flashes
- ☐ Vision - halos

Skin
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

WOMEN only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes

1st Day of last period_____

Are you pregnant? _____

Have you had a mammogram?_____

MEDICATIONS: List

_____

_____

_____

Surgeries: _____

_____

_____

_____

Diagnosed CONDITIONS: **Diagnosed by a Doctor in the past.**

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical depend
- ☐ Chicken pox
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problem
- ☐ Prosthesis
- ☐ Psychiatric care
- ☐ Rheumatoid arthritis
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors, growths
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease
- ☐ Whooping cough
- ☐ Other_____

_____

Medication Allergies:

☐ Ace Inhibitors ☐ Codeine ☐ Penicillin ☐ Sulfas;

Common Environmental Allergies:

☐ Bee Sting ☐ House Dust ☐ Latex ☐ Nuts/Peanuts

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_____ _____ _____

Patient Signature Date Reviewed By Doctor