CODY CHIROPRACTIC
WELLNESS CENTER LLC

PATIENT REGISTRATION & HEALTH HISTORY

462 Water St.
Prairie du Sac, WI 53578
(608)643-5060

Please answer each question completely. Write N/A if not applicable

First Name: _____
Mid. Name: _____
Last Name: _____
Address: _____
City_____
State_____ Zip_____

Phone: Home (_____) _____
Phone: Other (_____) _____ ☐Cell ☐Fax
Email Address_____
Date of Birth_____/_____/_____
☐ Male ☐ Female
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ other

Occupation_____ Employer_____Work (_____) _____
Spouse's Name_____ Children's Names and ages if applicable:_____
How did you hear about our office? _____

Please check any and all insurance coverage you have and/or the method of payment applicable, and complete all pertinent information.
☐Cash ☐ Medicare ☐Medicaid ☐ Health Insurance ☐ Other ☐ Auto Accident ☐ Worker's Compensation

What is you chief reason for consulting us?_____

Date of first symptom?_____
Is this problem the result of a (check all that apply): ☐Work Comp Injury ☐Motor Vehicle Accident ☐Unknown ☐Sports Injury

Have you been treated for this condition up to this point? (i.e., medications, other doctors, etc.):_____

_____
Do you suffer from any other medical conditions for which you are now consulting us? _____

List current medical doctors:_____

List any medications that you may be taking, including dosage:_____

List previous surgeries (reasons and dates):_____

List previous chiropractors (Names and approximate date of last adjustment):_____

How do you want us to address your condition? ☐ Maximum Correction ☐ Temporary Relief (Band aid)

DIETARY & NUTRITIONAL HABITS

Do you eat breakfast regularly?	☐Yes	☐ No
Do you use artificial sweeteners or foods with artificial sweeteners?	☐Yes	☐ No
Do you crave sweets regularly?	☐Yes	☐ No
Do you take vitamins?	☐Yes	☐ No

If yes, what vitamins do you take, how often, and how much?_____
If you do not take supplements, are you interested in information on supplements? ☐Yes ☐ No

Do you:

Smoke Tobacco?	☐No	☐Yes	If Yes, quantity/day _____
Drink Alcohol?	☐No	☐Yes	If Yes, quantity/day _____
Drink Coffee?	☐No	☐Yes	If Yes, quantity/day _____
Drink Pop/Soda?	☐No	☐Yes	If Yes, quantity/day _____

EXERCISE HABITS
Do you exercise? ☐ Yes ☐ No If yes, how often? ☐1-3X/week ☐3-5X/week ☐5-7X/week
Do you exercise at ☐ Home or ☐Gym? Please check all activities that you perform: ☐Walk ☐Run ☐ Bike ☐Stairstep
☐Aerobics ☐Weight Train ☐Stretching Exercises ☐ Roller Blading ☐Others _____

On a scale of 1-10 (10 being the most, and 1 being the least)

	How would you rate your quality of life right now?
	How committed are you at being at feeling your best?
	How important is it for your family to be at their optimum health potential?
	How committed would you like me and my staff to be?

What do you like to do for fun? (i.e., sports, hobbies, etc):_____

PAST HISTORY INFORMATION

List *all* previous falls and other accidents (Date and Describe):

Date	Injury involved in/at:	Description of Accident/Fall/Injury
	Automobile	
	School	
	Recreational Vehicle	
	Sports	
	Other	

WORK DESCRIPTION

ACTIVITY(Please check all that pertain to your workday)	0-33%	33-66%	66-100%
Sitting			
Standing			
Light Lifting (less than 25 pounds)			
Heavy Lifting (greater than 25 pounds)			
Bending			
Telephone			
Chronic repetitive motions			
Driving			

FAMILY HISTORY: Check if any member of your immediate family has/had any of the following:

☐Heart Disease ☐Diabetes ☐ Digestive Disorders ☐ Liver Disease ☐ Arthritis ☐ Other List:
☐Learning Disabilities ☐ Stroke ☐ H/L Blood Pressure ☐ Lung Disease ☐ Kidney Disease

INDICATE PROBLEMS THAT APPLY TO YOU: (**C** = Currently, **P** = in the Past)

DESCRIPTION	**C**	**P**	**DESCRIPTION**	**C**	**P**	**DESCRIPTION**	**C**	**P**	**DESCRIPTION**	**C**	**P**
Dizziness			Stomach Disorders			Rheumatism			Neck Pain/Stiffness		
Sinus Trouble			Thyroid Problems			Diabetes			Hand/Arm Pain ☐L ☐R		
Lung Trouble			Heart Trouble			Stroke			Shoulder Pain ☐L ☐R		
Allergies			Kidney Problems			Arthritis			Hip Pain ☐L ☐R		
Bursitis			Male Problems			Cancer			Leg Pain ☐L ☐R		
Colitis			Female Problems			HIV/AIDS			Sacroiliac Pain ☐L ☐R		
Depression			Skin Disorders			Pregnancy			Knee Pain ☐L ☐R		
Nervousness			Hearing Problems			Low Back Pain			Foot Pain ☐L ☐R		
Poor Appetite			Eczema			Mid Back Pain			Hand Weakness ☐L ☐R		
Gas			Numbness			Poor Circulation			Arm Weakness ☐L ☐R		
Ulcers			Stiffness			Epilepsy			Hand Numbness ☐L ☐R		
Constipation			Fainting			Headaches/Migraines			Arm Numbness ☐L ☐R		
Diarrhea			Swelling			Poor Health			Blood Pressure ☐H ☐L		

ASSIGNMENT, AUTHORIZATION AND POLICY STATEMENT

I believe that all information is complete to the best of my knowledge. *I will be responsible for any expenses the insurance carrier does not meet. This includes denial of services at any time during treatments that are deemed not medically necessary, considered as maintenance or wellness care by the third party payor.* I fully understand and agree that the insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are my responsibility. I hereby assign the benefits I am eligible to receive for the care rendered in this office. I authorize the office to release any information, to any insurance company, adjuster or attorney that will assist in payment of claims. A photocopy of this form will be considered as valid as the original.

Patient's Signature_____ Date_____ DC/CA Signature_____