Dr. Bill Janeshak
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CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Date _____
SS/HIC/Patient ID# _____
Patient Last Name _____
First Name _____ M. I. _____
Address _____
E-mail _____
City _____
State _____ Zip _____
Sex ☐ Male ☐ Female Age _____
Birth date _____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years
Patient Employer/School _____
Occupation _____
Employer/School Address _____

Employer/School Phone (_____) _____
Spouse's Name _____
Birth date _____ SS # _____
Spouse's Employer _____
How did you hear about our office ? _____

PHONE NUMBERS

Cell phone (_____) _____ Home phone (_____) _____
Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____
Home phone (_____) _____ Work phone (_____) _____

INSURANCE INFORMATION

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is Patient covered by additional insurance? ☐ Yes ☐ No
Subscriber's Name _____
Birth date _____ SS # _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____
all insured benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

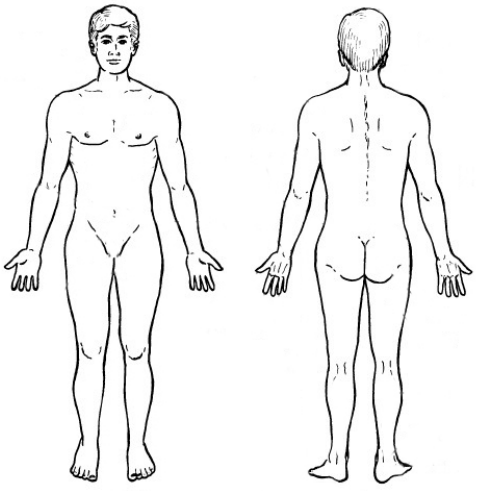
_____ _____
Date *Relationship to Patient*

ACCIDENT INFORMATION

Is condition due to accident? ☐ Yes ☐ No Date _____
Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other
To whom have you made a report of the accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other
Attorney Name (if applicable) _____

PATIENT CONDITION

Reason for visit _____
When did your symptoms appear? _____
Is this condition getting progressively worse?
☐ Yes ☐ No ☐ Unknown
Mark an X on the picture where you continue to have pain, numbness or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ Other _____

_____

Name and address of other doctor(s) who have treated you for 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 _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV ☐Yes ☐No	Emphysema ☐Yes ☐No	Migraine Headaches ☐Yes ☐No	Sexually Transmitted Disease ☐Yes ☐No
Alcoholism ☐Yes ☐No	Epilepsy ☐Yes ☐No	Miscarriage ☐Yes ☐No	Stroke ☐Yes ☐No
Allergy Shots ☐Yes ☐No	Fractures ☐Yes ☐No	Mononucleosis ☐Yes ☐No	Suicide Attempt ☐Yes ☐No
Anemia ☐Yes ☐No	Glaucoma ☐Yes ☐No	Multiple Sclerosis ☐Yes ☐No	Thyroid Problems ☐Yes ☐No
Anorexia ☐Yes ☐No	Goiter ☐Yes ☐No	Mumps ☐Yes ☐No	Tonsillitis ☐Yes ☐No
Appendicitis ☐Yes ☐No	Gonorrhea ☐Yes ☐No	Osteoporosis ☐Yes ☐No	Tuberculosis ☐Yes ☐No
Arthritis ☐Yes ☐No	Gout ☐Yes ☐No	Pacemaker ☐Yes ☐No	Tumors, Growths ☐Yes ☐No
Asthma ☐Yes ☐No	Heart Disease ☐Yes ☐No	Parkinson's Disease ☐Yes ☐No	Typhoid Fever ☐Yes ☐No
Bleeding Disorders ☐Yes ☐No	Hepatitis ☐Yes ☐No	Pinched Nerve ☐Yes ☐No	Ulcers ☐Yes ☐No
Breast Lump ☐Yes ☐No	Hernia ☐Yes ☐No	Pneumonia ☐Yes ☐No	Vaginal Infections ☐Yes ☐No
Bronchitis ☐Yes ☐No	Herniated Disc ☐Yes ☐No	Polio ☐Yes ☐No	Whooping Cough ☐Yes ☐No
Bulimia ☐Yes ☐No	Herpes ☐Yes ☐No	Prostate Problem ☐Yes ☐No	Other _____
Cancer ☐Yes ☐No	High Blood Pressure ☐Yes ☐No	Prosthesis ☐Yes ☐No	
Cataracts ☐Yes ☐No	High Cholesterol ☐Yes ☐No	Psychiatric Care ☐Yes ☐No	
Chemical Dependency ☐Yes ☐No	Kidney Disease ☐Yes ☐No	Rheumatoid Arthritis ☐Yes ☐No	
Chicken Pox ☐Yes ☐No	Liver Disease ☐Yes ☐No	Rheumatic Fever ☐Yes ☐No	
Diabetes ☐Yes ☐No	Measles ☐Yes ☐No	Scarlet Fever ☐Yes ☐No	

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking
☐ Alcohol
☐ Coffee/Caffeine Drinks
☐ High Stress Level

Packs/Day _____
Drinks/Week _____
Cups/Day _____
Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

Pharmacy Name: _____

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