CHIROPRACTIC REGISTRATION & HISTORY

Rocky Mount Chiropractic, LLP
116 North Circle Drive Rocky Mount, NC 27804 (252)451-0039
ROCKYMOUNTCHIROPRACTIC.COM

PATIENT INFORMATION

Date_____

Name_____
LAST NAME FIRST NAME INITIAL

Address_____

_____
CITY STATE ZIP

Sex: ❑ M ❑ F Age___ Birthdate_____
❑ Single ❑ Married ❑ Widowed
❑ Separated ❑ Divorced

SS# _____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouses Name_____

Birthdate_____ SS#_____

Occupation_____

Spouses Employer_____

Home #_____ Work #_____

Cell#_____ Other#_____

Best time/place to reach you? _____

IN CASE OF EMERGENCY CONTACT

Name_____ Relationship _____

Home #_____ Work # _____

CONSENT TO TREAT

I hereby authorize Dr. Peterson to treat my condition, as she deems appropriate. The patient also agrees he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed condition or for any medical diagnosis.

Patient Signature_____ Date_____

AUTHORIZATION AND RELEASE

I hereby authorize to release any information Rocky Mount Chiropractic, PLLC, Dr. Peterson deems appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred. I authorize the direct payment to Rocky Mount Chiropractic, PLLC, Dr. Peterson for any sum I now or hereafter owe, by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or Rocky Mount Chiropractic, PLLC, Dr. Peterson based in whole or in part upon the charges made for your services. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due. I personally owe Rocky Mount Chiropractic, PLLC.

Patient Signature_____ Date_____

PATIENT CONDITION

Reason for visit? _____
When did your symptoms begin?_____
Is your condition getting progressively worse? ❑ No ❑ Yes
Is your pain: ❑ Mild ❑ Moderate ❑ Severe
Type of Pain:
❑ Sharp ❑ Dull ❑ Throbbing ❑ Numb ❑ Achy
❑ Shooting ❑ Burning ❑ Tingling ❑ Stiff ❑ Other
How Often do you have this pain?_____ Is this pain constant or come and go?_____
Does it interfere with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation
Which movements are Painful? ❑ Sitting/Bending ❑ Standing ❑ Walking ❑ Lying Down

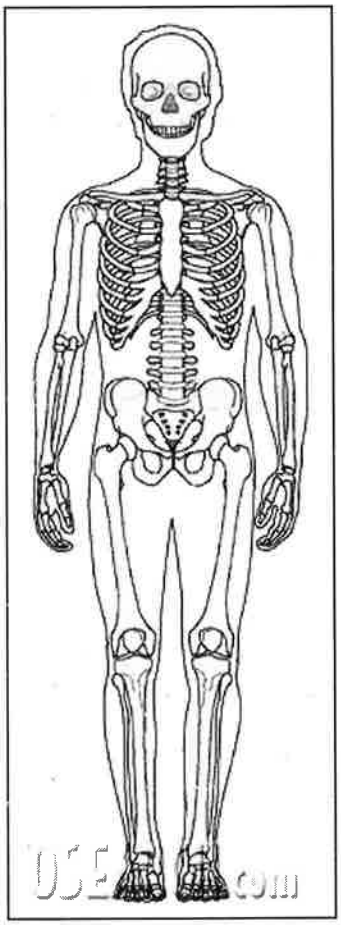
PAIN DRAWING

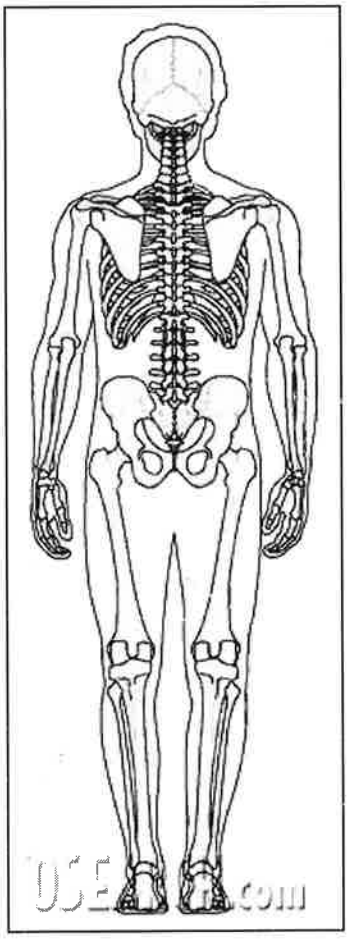
DATE_____ NAME_____

Circle the location of your pain on the body outline. Mark your degree of pain (using numbers 1 thru 10)

[ ] Ache [ ] Burning [ ] Numbness [ ] Pins & Needles

[ ] Stabbing [ ] Other_____





Please circle degree of pain here: **1 2 3 4 5 6 7 8 9 10** (with 1 being the least pain and 10 being the worst pain).