PATIENT REGISTRATION

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms. ❑ Dr.	Marital status (circle one)
					Single / Mar / Div / Sep / Wid / DP

Is this your legal name?	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:
❑ Yes ❑ No			/ /		❑ M ❑ F

Street Address:	Social Security no.:	Home phone no.:
		( )

City:	State:	ZIP Code:	❑ Work or ❑ Cell no.:
			( )

Occupation:	Employer:	Employer phone no.:
Years:		( )

Who do we thank for referring you to this office?	(Please check one box) ❑ Family ❑ Friend ❑ Close to home/work ❑ Other
May we send a note of thanks? ❑ Yes ❑ No	Name of referral:

Other family members seen here?	Name	Relationship
❑ Yes ❑ No		
Email Address:		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship?	Home phone no.:	❑Work or ❑Cell no.:
		( )	( )
		( )	( )

- The above information is true to the best of my knowledge. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will immediately be due and payable.
- I hereby authorize Dr. Milligan / Dr. Coleman to treat my condition as he/she deems appropriate through the use of exams, X-rays and the manipulation throughout my spine.
- All X-ray negatives are the property of this office.
- Dr. Milligan / Dr. Coleman will not be held responsible for any pre-existing medically diagnosed conditions, nor medical diagnosis.
- I give my permission to receive reminder calls and notifications from this office.
- By signing this form, you are also stating the following: I authorize the release of any medical or other information necessary to process my claim. I authorize payment of medical benefits to Dr. Stephen R. Milligan / Dr. Michelle L. Coleman, for services rendered.

Patient Signature ____________________ *Date* ____________

Printed Guardian Name / Guardian Signature ____________________ *Date* ____________

STEPHEN R. MILLIGAN, D.C. / MICHELLE L. COLEMAN, D.C.

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME *(Last, First, M.I.)*: ☐ M ☐ F **DOB:** / /

MARITAL STATUS: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

PREVIOUS CHIROPRACTIC CARE: ☐ None
☐ Doctor's name & and last office visit:

Current Health Condition

Purpose of this appointment:

Other doctors seen for this condition? ☐ YES ☐ NO Name of doctor:

Types of treatments/tests:
☐ X-Ray
☐ MRI
☐ CT Scan
☐ Shoe Lift (L) (R)

Results/Comments:

When did this condition begin?	Has this condition occurred before?	☐ YES ☐ NO

Is Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other:

Date of accident: Time of Accident:-

Have you made a report of your accident to your employer: ☐ Yes ☐ No

Circulatory/Neurology Have you recently or ever experienced the following (check all that apply):

- ☐ Drop attacks
- ☐ Extreme dizziness with loss of balance
- ☐ Ringer in ears – Tinnitus
- ☐ Unexplained blurred vision
- ☐ Unusual headaches
- ☐ Recent memory problems
- ☐ Stroke (CVA)
- ☐ Mini Stroke
- ☐ Transient ischemic attack
- ☐ Unexplained changes in mood

Do you suffer from any condition other then that which you are now consulting us?

Drugs you now take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxants ☐ Blood Pressure Medicine ☐ Insulin ☐ Other

List your prescribed drugs and over-the-counter drugs, such as vitamins, supplements and inhalers

Name of Drug/supplement	Strength	Frequency Taken

☐ Please check if you used the back of this page to provide additional information