

Kelly W. Crooks, D.C.

382 W. Chestnut Street
Suite 103
Washington, PA 15301

WASHINGTON
CHIROPRACTIC
CENTER, INC.
www.washchiro.com

Phone: (724) 225-1655
Fax: (724) 225-6670

REGISTRATION INFORMATION

Date: _____

Cell Phone: _____

PLEASE PRINT

E-mail: _____

(Please circle one) Dr., Mr., Mrs., Ms., Miss

Home Phone: (____) _____

First Name: _____ MI: ____ Last Name: _____ Social Security #: _____

Street Address: _____ City _____ State: ____ Zip: _____

Sex: M F Date of Birth: _____ Age: ____ Marital Status: Single Married Divorced Widowed Separated

Children: _____ Education Level obtained: _____ Referred to our office by: _____

Spouse's Name: _____ Spouse's Occupation: _____

Primary Care Physician (name, address & telephone): _____

Employer and Employer's Address: _____

Work Phone: (____) _____ Occupation: _____

Student Status: Full Time Part Time Name of School: _____

If you are the responsible party, mark "self" and move down to "Insurance Information".

Patient's relationship to responsible party: Self Spouse Dependent

First Name: _____ MI: ____ Last Name: _____ Social Security #: _____

Street Address: _____ City _____ State: ____ Zip: _____

Sex: M F Date of Birth: _____ Age: ____ Marital Status: Single Married Divorced Widowed Separated

Employer and Employer's Address: _____

Work Phone: (____) _____ Occupation: _____

INSURANCE INFORMATION

Insurance Company: _____ Insurance Company's telephone #: (____) _____

Insurance Company's Address: _____

Group or Policy Number: _____ Subscriber or I.D. #: _____

Secondary Insurance: _____ Insurance Company's telephone #: (____) _____

Insurance Company's Address: _____

Group or Policy Number: _____ Subscriber or I.D. #: _____

RELEASE AND ASSIGNMENT

1. I authorize the release of any medical information necessary to process my insurance claim(s)
2. I authorize and request payment of medical benefits directly to Washington Chiropractic Center
3. I agree that this authorization will cover all medical services rendered until such authorization is revoked in writing by me.
4. I agree that a photocopy of this form may be used in lieu of the original.
5. I hereby consent to any procedures or treatment for my condition as deemed necessary by the attending doctors at Washington Chiropractic Center, Inc.

Signed (patient or representative) _____ / ____ / ____
Date

Patient's Name (Printed)

ATTENTION: Payment is to be made at the time of the visit unless prior arrangements have been made with this office. Also a 24-HOUR NOTICE is necessary to cancel an appointment, and you may be responsible for payment of a missed appointment.

Kelly W. Crooks, D.C.

382 W. Chestnut Street
Suite 103
Washington, PA 15301

WASHINGTON
CHIROPRACTIC
CENTER, INC.
www.washchiro.com

Phone: (724) 225-1655

Fax: (724) 225-6670

PRESENT HISTORY

Name: _____

Date: _____

MAIN COMPLAINT: Why are you here today? Be specific with location: _____

1. When did it start? Date: _____

2. How did it start? Explain: _____

3. Recent work-related injury? Y N • Recent auto accident? Y N • Injury at home? Y N • Injury elsewhere Y N

4. Does it radiate to any other part of your body? Y N Where? _____

5. Did it begin gradually or suddenly? _____

6. How would you describe the intensity? (mild, moderate, severe) _____

7. Describe your pain (dull, sharp, burning, numbness, soreness, stiffness): other: _____

8. Has your problem been getting worse, better, or about the same? _____

9. Does your condition come and go or is it all the time? _____

10. What makes your symptoms better? _____

11. What makes your symptoms worse? _____

12. Have you tried home remedies? Y N Details _____

13. What doctors have you seen and what test have been done for your condition? _____

14. Have you had anything like this before? Y N What? _____

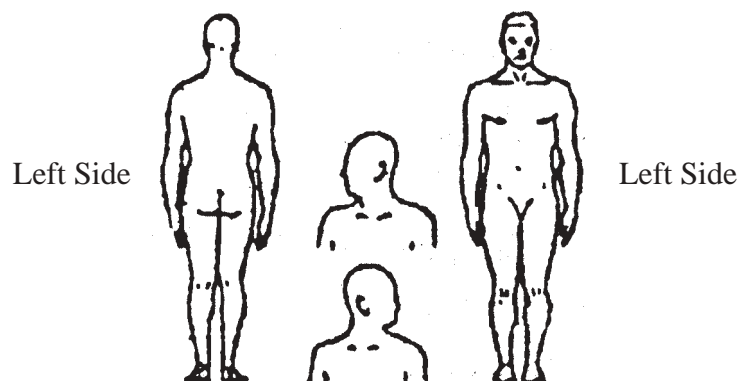
15. Have there been any other changes in any body functions? Y N Details: _____

16. Has your condition affected your daily activities in any way? Y N Explain: _____

17. Have you been unable to work as a result of your current problem? _____

18. Do you have any other problems that you would like the doctors to evaluate? _____

Please mark location of pain on diagram.



Kelly W. Crooks, D.C.

382 W. Chestnut Street
Suite 103
Washington, PA 15301

WASHINGTON
CHIROPRACTIC
CENTER, INC.
www.washchiro.com

Phone: (724) 225-1655
Fax: (724) 225-6670

PAST HISTORY

1. Have you had any of the following diseases: (Circle) Measles, Rubella, Chickenpox, Mumps, Scarlet Fever, Rheumatic Fever, Tuberculosis, HIV, Hepatitis, Other: _____
2. Have you been diagnosed with any other conditions? Y N Explain: _____
3. Are you under a doctor's care presently for any type of health problem? _____
4. Have you had any broken bones? Y N Which ones? _____
5. Have you ever had any past significant auto accidents, work injuries or falls? Y N When? _____
6. Are you taking any medications? Please list. _____

7. Have you ever undergone any type of surgery? What and when? _____

8. Do you smoke, drink alcohol or use recreational drugs? _____
9. Do you have any allergies? _____
10. Do any diseases run in the family? _____

SYSTEM REVIEW

HAVE YOU BEEN DIAGNOSED OR BEEN TOLD YOU HAVE THE FOLLOWING?

- | | |
|--|---|
| Y N High blood pressure | Y N Slurred speech or other speech problems |
| Y N Hardening of the arteries | Y N Difficulty swallowing |
| Y N Diabetes | Y N Dizziness |
| Y N Heart or blood vessel disease | Y N Temporary lack of understanding |
| Y N Bone spurs on the neck (cervical spondylosis) | Y N Loss of consciousness, even momentary blackouts |
| Y N Whiplash injury | Y N Numbness or loss of sensation in the face, arms, hands, fingers, or legs |
| Y N Have any of your relatives ever suffered a stroke? | Y N Any other abnormal or loss of sensation in any other part of the body |
| Y N Blurred vision | Y N Weakness, clumsiness, or strength loss in the face, arms, hands, fingers, or legs |
| Y N Double vision | Y N Ringing, buzzing, or any noise in the ears |
| Y N Diminished or partial loss of vision in one or both eyes | |
| Y N Complete loss of vision in one of both eyes | |
| Y N Sudden collapse without loss of consciousness | |
| Y N Hearing loss in one or both ears | |

WOMEN ONLY:

- Do you experience any of the following symptoms?
- Y N Do you take birth control pills? How long? _____
- Y N Menstrual pain
- Y N Cramping
- Y N Irregularity
- Y N Date of last period _____
- Y N Are you now pregnant? _____ How long? _____

MEN ONLY:

- Date of last prostate exam: _____
- Difficulty with urination? Y N Explain _____
- Excessive urination? Y N Explain _____

I hereby consent to any procedures or treatments for any condition as deemed necessary by the attending doctors at **Washington Chiropractic Center, Inc.**

Patient's Signature: _____ Date: ___/___/___