# Patient Registration and History:

*Absolute Chiropractic Care – Lanham, LLC*
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## Your Information

Date:_____ Sex: ⊙Male ○Female

Name:_____
First Last Initial

Address: _____

_____

Home #: _____ Cell #: _____

SSN #: _____ Work #: _____

Age: _____ Date of Birth: _____

⊙Single ○Married ○Divorced ○Widowed

Height: _____ Weight: _____ Right ⊙ or Left ○ handed

Employer: _____

Occupation: _____

Work Address: _____

In case of emergency, please contact

Name: _____

Phone #: _____ Relationship: _____

Is your condition/visit due to an automobile accident?

○YES ●NO

If yes, please continue with Accident Information.
If no, please skip to Insurance Information.

## Your Insurance Information

Health Insurance Co.: _____

Phone #: _____ Policy #: _____

Policy Holder Name: _____

Your relationship to policyholder: _____

**Automobile Accidents (complete)**

Owner of the vehicle you were injured in:

Name: _____

Insurance Co.: _____

Phone #: _____ Policy #: _____

Claim #: _____ Adjuster: _____

Have you retained an attorney? YES○NO⊙

Name & Phone #: _____

Has accident been reported? YES⊙NO○

**Third Party Insurance (the person that hit you):**

Name: _____

Insurance Co.: _____

Phone #: _____ Policy #: _____

Claim #: _____ Adjuster: _____

**Accident Information:** Date of Injury:_____ Time:_____ AM⊙PM○ State: ___ You braced for impact: YES○NO⊙

You were the: ⊙ Driver ○ Front Passenger ○ Rear Passenger You were seatbelted: YES⊙NO○ Police Report Filed: YES⊙NO○

How did the accident occur? _____

_____

Struck from: Rear ○ Front ○ L-side ⊙ R-side ○ Did you know you were going to be hit? YES○NO⊙ Others in your car? YES○NO⊙

Approximate speed of your vehicle (or Stopped): ____mph Make/Model of your car: _____

Approximate speed of your other vehicle: ____mph Make/Model of other car: _____

Approximate damage to your car: Minimal⊙Moderate○ Extensive○ Totaled○

Did you go to the hospital? YES○NO⊙ If YES, when? _____ Hospital: _____

X-Rays taken? YES⊙NO○ of my: _____ How did you get to the hospital? _____

Medication prescribed: _____

Have you seen any other doctors (not including us) since the accident: YES○NO⊙ If yes, who: _____

What treatment was given: _____

## Medical History

| Injuries/Surgeries you may have had | Description | Date(s) |
|---|---|---|
| Auto Accident(s) | _____ | _____ |
| Work Injuries | _____ | _____ |
| Broken Bones | _____ | _____ |
| Surgeries | _____ | _____ |

### HAVE YOU EVER BEEN DIAGNOSED AS HAVING OR SUFFERING FROM (CHECK ALL THAT APPLY)

| | | |
|---|---|---|
| ☐ Muscle disorder | ☐ Lungs, Asthma | ☐ Osteoarthritis |
| ☐ Nervous disorder | ☐ Broken bones | ☐ Epilepsy |
| ☐ Bone disorder | ☐ Eating disorder | ☐ Alcoholism |
| ☐ Rheumatoid Arthritis | ☐ Pace maker | ☐ Drug addiction |
| ☐ Allergies | ☐ Seizures/Convulsions | ☐ Strokes |
| ☐ HIV | ☐ A congenital disease | ☐ Cancer |
| ☐ Gallbladder | ☐ Excessive bleeding | ☐ Ulcer |
| ☐ Diabetes | ☐ High blood pressure | ☐ Hernias |
| ☐ Depression | ☐ Low blood pressure | ☐ Ears, Eyes, Nose, Throat problem |
| ☐ Coughing blood | ☐ Kidney, Bladder (GU) | ☐ Tumors |
| ☐ Stomach, intestines (GI) | ☐ Circulatory problems | ☐ Heart disease |

**Please list all medications you are currently taking:** _____

_____

Are you currently under a doctor's care for anything NOT listed above: YES○ NO○ If yes, explain: _____

_____

Primary Physician Name: _____ Phone #: _____

**Female Patients:** Date of last menstrual cycle: _____ Are you pregnant? YES○ NO○

## Your Condition

What are your present complaints: _____

_____

When did the symptoms first appear: _____

Does if interfere with: Sleep○ Daily Routine○ Work○ Recreation○

Activities that are painful to perform: Sitting○ Standing○

Walking○ Bending○ Lying Down○ Other ○_____

_____

Lost time from work due to your injuries? YES○ NO○

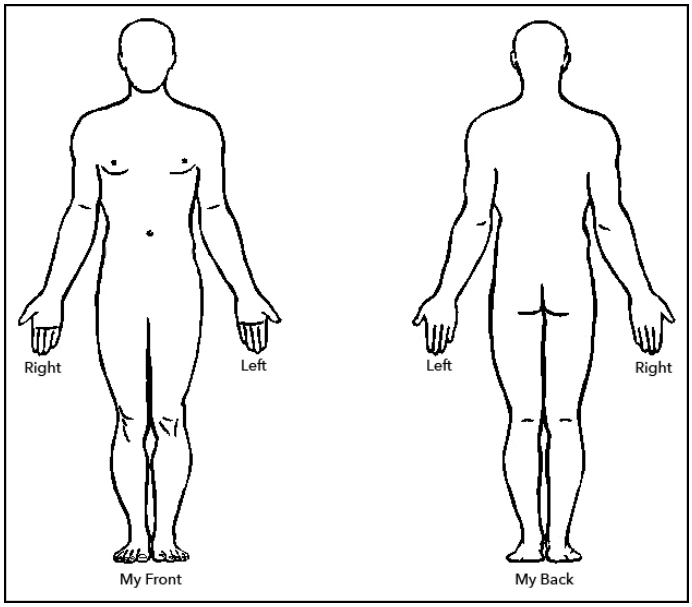
How much time lost from work? _____

Any cuts or bruises: YES○ NO○ If yes, where: _____

Since the accident my symptoms are:

Improving○ About the same○ Getting worse○

## PLEASE MARK AN "X" ON DRAWING TO INDICATE PAIN



**Authorization for Treatment:** I hereby authorize the Doctor to treat my condition as he/she deems appropriate and to furnish any authorized requests for information regarding treatment. It is understood and agreed that the amount paid for the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while the patient is being treated at this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for preexisting medically diagnosed conditions, nor for any medical diagnosis. The patient also agrees that the statements made in this questionnaire are true and correct.

**Patient/Guardian Signature: _____**

**X-Ray Authorization:** I have been informed that x-rays may be damaging to my health. I also declare that I am NOT pregnant. I give the Doctor's office the authority to x-ray me as a diagnostic aid in evaluating my case.

**Patient/Guardian Signature: _____**

THANK YOU FOR TAKING TIME TO COMPLETE YOUR COMPREHENSIVE CASE HISTORY.
WE LOOK FORWARD TO WORKING WITH YOU AS A PARTNER IN YOUR EHALTH AND RECOVER.
PLEASE FEEL FREE TO ASK ANY QUESTIONS YOU MAY HAVE AT ANY TIME.