WOLF
CHIROPRACTIC CLINIC P.C.

2610 2nd Ave
Kearney, NE 68847

PATIENT REGISTRATION

Date: _____

Patient Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____ E-mail:_____

Phone:_____ Soc.Sec.No.:_____ Sex: M/F____ Marital Status: _____

Employer:_____ Occupation_____ Work Phone:_____

Emergency Contact:_____ Relationship to Patient:_____ Phone:_____

Is this related to: *-Auto Accident -Worker's Compensation -Personal Injury -Other*_____

***How did you hear about us? Who may we thank for referring you?_____

CASE HISTORY

PRESENT CONDITION:
Major complaint(s) and symptom(s): _____
_____
_____
When did this happen? _____
_____
What were you doing? _____
_____
Has the problem progressed? Y/N

Type of pain*: -Ache -Numbing -Shooting -Tingling(pins)* Rate the pain (1-10;10=severe) ___

What do you do to make the problem feel better? _____
_____
_____
What makes your problem worse? _____
_____
_____
Has this happened before? Y/N If yes, how often? _____
_____
Have you seen another doctor for this problem? Y/N Medical/Chiropractor?_____
_____
Name of Doctor: _____ Type of Treatment: _____
_____

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HEALTH QUESTIONNAIRE

If you have ever had a listed condition in the past, please check it in the past column. If you are presently troubled by a particular condition, check it in the present column.

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
__	__	Neck pain (723.1)	__	__	Rapid heart beat (785.0)	__	__	Heart attack (410.9)
__	__	Shoulder pain (719.41)	__	__	Chest pains (786.50)	__	__	Aneurysm (441.5)
__	__	Pain in arm/elbow (719.42)	__	__	Heartburn/Indigestion (787.1)	__	__	Angina (413.9)
__	__	Hand pain (719.44)	__	__	Excessive thirst (783.5)	__	__	High blood pressure
__	__	Wrist (719.43)	__	__	Abnormal weight loss	__	__	Stroke (436)
__	__	Upper back pain (724.1)	__	__	Abnormal weight gain	__	__	Asthma (493.9)
__	__	Low back pain (724.2)	__	__	Chronic cough (786.2)	__	__	Cancer (199.1)
__	__	Pain in upper leg/hip (719.45)	__	__	Chronic sinusitis (473.9)	__	__	Tumor (229.9)
__	__	Pain in lower leg/knee (729.5)	__	__	General fatigue (780.7)	__	__	Arthritis (716.9)
__	__	Pain in ankle or foot (719.47)	__	__	Menstrual problems	__	__	Diabetes (250.0)
__	__	Jaw pain (526.9)	__	__	Endometriosis (617.9)	__	__	Epilepsy (349.5)
__	__	Swelling/stiffness of joints	__	__	PMS (625.4)	__	__	Ulcer (556.9)
__	__	Fainting (780.2)	__	__	Kidney/bladder problems	__	__	HIV/AIDS
__	__	Visual disturbances (368.9)	__	__	Abdominal pain (789.0)	__	__	Blood disorder
__	__	Convulsions (780.3)	__	__	Constipation (564.0)	__	__	Liver disorder
__	__	Dizziness (780.4)	__	__	Skin problems (692.9)	__	__	Gallbladder problems
__	__	Headache (784.0)	__	__	Depression (311)	__	__	Colitis (558.9)
__	__	Tinnitus (ear noises) (388.30)	__	__	Difficulty swallowing	__	__	Bladder infection
__	__	Allergies	__	__	Numbness/Tingling	__	__	Weakness

Other Complaints: _____

_____

Please list any past surgeries and hospitalizations: _____

_____

Do you have any blood relatives with:

Cancer	Y/N	Who?	_____
Hypertension	Y/N	Who?	_____
Cardiovascular	Y/N	Who?	_____
Diabetes	Y/N	Who?	_____
Arthritis	Y/N	Who?	_____

Please Read Carefully and initial:

Payment is expected at time of service including all co-pay and deductible amounts. Should you have a balance for any reason after your insurance has processed, a statement will be sent to you. It will be your responsibility to pay the balance due. Medicare Patients please note that exams and therapies performed in this office are NOT covered by Medicare and most secondary insurances

_____ Patient Initials

It is the patient's responsibility to fully understand their own insurance benefits. The patient is also responsible for keeping track of the number of visits allowed and the number of visits used, regardless of where the services have been performed. The information provided to me by this clinic does not guarantee coverage for the services performed.

_____ Patient Initials

I understand that I am liable for any unpaid services that were performed in this clinic that insurance does not pay. I authorize the release of any medical records that might be necessary to facilitate payment of services and authorize the insurance company to make payments directly to the doctors. I understand that the doctors in this office have access to each other's records without further authorization.

_____ Patient Initials

Patient or Guardian's Signature: _____ Date: _____