Coastline Health and Chiropractic

PATIENT REGISTRATION

PATIENT INFORMATION

Name: Last_____ First_____ DOB _____ Age___ **Male/Female**

Address_____ City_____ State____ Zip_____

Home Phone (___) _____ Work (___) _____Cell (___) _____

Social Security # ____-____-____ Drivers License # _____

Email Address _____

EMERGENCY CONTACT INFORMATION

Name: Last_____ First_____ Relationship: _____

Address_____ City_____ State____ Zip_____

Home Phone (___) _____ Work (___) _____Cell (___) _____

INSURANCE INFORMATION

Insurance Company Name_____ Insurance Phone # (___)_____

Insured's Name (If not the patient) Last _____ First _____ MI ___

DOB _____ Age _____ (circle one) **Male/Female** Policy # _____

Relationship to Insured (circle one): Self/Spouse/Child/Other _____

HIPPA – NOTICE OF PRIVACY PRACTICES – I acknowledge that a copy of the Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, protected, and how I can get access to this information is available to me upon request.

PATIENT PAYMENT AGREEMENT

- ☐ I, the undersigned, do not have insurance coverage. I agree to pay all charges at the time service is rendered, unless prior arrangements have made.
- ☐ I, the undersigned, have insurance coverage and assign directly to Dr. Fassino, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Patient Signature: _____ **Date:** _____

General Symptoms: *Check all that apply past or present.*

General
- ☐ Bruise easily
- ☐ Chills
- ☐ Dental problems
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Tiredness
- ☐ Weight gain

Genito-Urinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision- flashes
- ☐ Vision- halos

Skin
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

Men Only
- ☐ Breast lump
- ☐ Errectile difficulties
- ☐ Lump in testicles
- ☐ Penile discharge
- ☐ Sore on penis
- ☐ Other: _____

_____

Women Only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other: _____

Date of last menstrual period: _____

Date of last pap smear: _____

Have you had a mammogram? _____

Are you pregnant? ☐ Y ☐ N

Neck, Back & Extremities: *Check all that apply past or present.*

Neck
- ☐ Pain in neck
- ☐ Neck stiffness
- ☐ Neck weakness
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding/popping

Mid-Back
- ☐ Mid-back pain
- ☐ Mid-back stiffness
- ☐ Pain between should blades
- ☐ Pain from front to back
- ☐ Muscle spasms in mid-back

Low Back
- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Low back weakness
- ☐ Pinched nerve in low back
- ☐ Low back feels out of place
- ☐ Muscle spasms in low back

Shoulders
- ☐ Pain in shoulder joint ☐ R ☐ L
- ☐ Pain across shoulders ☐ R ☐ L
- ☐ Can't raise arm ☐ R ☐ L
  - ☐ Above shoulder level ☐ R ☐ L
  - ☐ Over head ☐ R ☐ L
- ☐ Pinched nerve in shoulder ☐ R ☐ L

Hips, Legs & Feet
- ☐ Pain in buttocks ☐ R ☐ L
- ☐ Pain in hip joint ☐ R ☐ L
- ☐ Pain down leg ☐ R ☐ L
- ☐ Pain in knee ☐ R ☐ L
- ☐ Pain in ankle ☐ R ☐ L
- ☐ Pain in foot ☐ R ☐ L
- ☐ Weakness of leg ☐ R ☐ L
- ☐ Weakness of knee ☐ R ☐ L
- ☐ Leg cramps ☐ R ☐ L
- ☐ Other: _____

_____

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any of his/her staff responsible for any errors or omissions that I may have made in

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____

Coastline Health & Chiropractic

Patient Questionnaire

Date: _____

Patient Name: _____ Bithdate: _____

Reason for Visit: _____

Have you been treated before for this problem? ☐ Yes ☐ No

If yes, ☐ Phsyician ☐ Doctor of Chiropractic Physical Therapist ☐ Osteopath ☐ Other: _____

What did they do/ or recommend? _____

Is it constant or does it come and go? _____ When did your symptoms appear?

Does it interfere with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying Down

☐ Other: _____ Your Occupation: _____

Have you ever had chiropractic care for other problems? ☐ No ☐ Yes When? _____

Do you take: ☐ Muscle Relaxers ☐ Pain Killers ☐ Insulin ☐ Birth Control Pills ☐ Over-the-counter medication

Other prescription drugs: _____

Date of last: Physical Exam: _____ Spinal X-ray: _____ Blood Test: _____

Spinal Exam: _____ Chest X-ray: _____ Urine Test: _____

Dental X-ray: _____ MRI/CT/Bone Scan: _____

Sleep _____ hrs/night Do you sleep on your ☐ Back ☐ Side ☐ Stomach Non-job exercise _____ hrs/week

Age of mattress: _____ or Waterbed: _____ Is your bed comfortable ☐ Yes ☐ No

What kind of pillow do you use? ☐ Thick ☐ Medium ☐ Thin ☐ None ☐ Support Other: _____

Do you wear ☐ Heel Lifts ☐ Shoe Lifts ☐ Arch Supports ☐ Orthotics, describe _____

Conditions: *Check all that apply past or present.*

☐ AIDS	☐ Diabetes	☐ Liver Diease	☐ Rheumatic fever
☐ Alcoholism	☐ Emphysema	☐ Measles	☐ Scarlet fever
☐ Anemia	☐ Epilepsy	☐ Migraine Headaches	☐ Stroke
☐ Anorexia	☐ Fractures	☐ Miscarriage	☐ Suicide attempt
☐ Appendicitis	☐ Glaucoma	☐ Mononucleosis	☐ Thyroid Problems
☐ Arthritis	☐ Goiter	☐ Multiple Sclerosis	☐ Tonsilitis
☐ Asthma	☐ Gonorrhea	☐ Mumps	☐ Tuberculosis
☐ Bleeding disorder	☐ Gout	☐ Osteoporosis	☐ Tumors; growths
☐ Breast lump	☐ Heart Disease	☐ Pacemaker	☐ Typhoid fever
☐ Bronchitis	☐ Hepatitis	☐ Pneumonia	☐ Ulcers
☐ Bulimia	☐ Hernia	☐ Polio	☐ Vaginal Infections
☐ Cancer	☐ Herpes	☐ Prostate Problem	☐ Venereal Disease
☐ Cataracts	☐ High Cholesterol	Prosthesis	☐ Whooping cough
☐ Chemical Dependency	☐ HIV positive	☐ Psychiatric care	Other: _____
☐ Chicken Pox	☐ Kidney Disease	☐ Rheumatoid arthritis	_____

Medications: *List medications you are currently taking.*	**Vitamins/ Herbs/ Minerals**
Allergies:	
Pharmacy Name: Phone:	