COASTLINE HEALTH & CHIROPRACTIC

Julio C. Fassino, D.C.
CEO/Chiropractor
CA License 19111

Patient Registration

Patient Information

Last Name: _____ First Name: _____ DOB: _____ Age:_____

Gender: ___ Male ___Female ___Other: _____ Preferred Pronouns: _____

Address:_____City: _____ State: _____ Zip: _____

Cell Phone: _____ Secondary Phone: _____

Social Security Number: _____ Driver's License #: _____

Email Address:_____

Emergency Contact Information

Last Name: _____ First Name: _____Relationship: _____

Address:_____City: _____ State: _____ Zip: _____

Cell Phone: _____ Secondary Phone: _____

Insurance Information

Insurance Company Name: _____ Insurance Phone #:_____

Insurance Identification Number: _____ Insurance Group Number: _____

Name of Insured Last: _____ First: _____ MI: _____

DOB: _____ Age:_____ Gender: ___ Male ___Female ___Other: _____

Relation to Insured: ___Self ___Spouse/Partner ___Child ___Other: _____

HIPPA – Notice of Privacy Practices

I acknowledge that a copy of the Notice of Privacy Practices that outlines how patient confidentiality 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 been 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 hereby 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: _____

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General Symptoms (check all that apply, x for past and ✓ for present)

General
___ 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 heartbeat
___ Low blood pressure
___ Poor circulation
___ Rapid heartbeat
___ 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
___ Erectile difficulties
___ Lump in testicles
___ Penile discharge
___ Sore on penis
___ Other

Women Only
___ Abnormal pap smear
___ Abnormal vaginal discharge
___ Bleeding between periods
___ Breast lump
___ Extreme menstrual pain
___ Hot flashes
___ Nipple discharge
___ Other

Date of last menstrual period
_____

Date of last pap smear
_____

Date of last mammogram
_____

Are you pregnant?
___ Yes ___ No

Neck, Back, and Extremities (check all that apply, x for past and ✓ for 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 shoulder blades
___ Pain from front to back
___ Muscle spasms in mid-back

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

Shoulders
___ Pain in shoulder joint Right/Left
___ Pain across shoulders Right/Left
Can't raise arms Right/Left
___ Above shoulder level
___ Over head
___ Pinched nerve in shoulder Right/Left

Hips, Legs, Feet
___ Pain is buttocks Right/Left
___ Pain in hip joint Right/Left
___ Pain down leg Right/Left
___ Pain in knee Right/Left
___ Pain in ankle Right/Left
___ Pain in foot Right/Left
___ Weakness of leg Right/Left
___ Weakness of knee Right/Left
___ Leg cramps Right/Left

Other: _____
_____

Medical History

List all surgeries/medical procedures: _____
_____
_____

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 have made.

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____

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Patient Questionnaire

Date: _____

Patient Name: _____ Birth date: _____

Reason for visit: _____

Have you been treated before for this issue? ___Yes ___No

If yes: ___Physician ___Doctor of Chiropractic ___Physical Therapist ___Osteopath ___Other_____

What did they do or recommend? _____

Is it: ___Constant ___Frequent ___Occasional 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_____

Have you ever had chiropractic care for other issues? ___Yes ___No When? _____ Why?_____

My occupation is: ___Sedentary ___Active ___Requires heavy lifting Non-job exercise: _____hours/week

Date of Last:

Physical exam _____ Dental x-ray _____ Blood test _____

Spinal exam _____ Spinal x-ray _____ Urine test _____

MRI/CT/Bone scan _____ Chest x-ray _____

Sleep: _____hours/night Do you sleep on your: ___Back ___Side ___Stomach

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, x for past and ✓ for present)

___ AIDS
___ Alcoholism
___ Anemia
___ Anorexia
___ Appendicitis
___ Arthritis
___ Asthma
___ Bleeding disorder
___ Breast lump
___ Bronchitis
___ Bulimia
___ Cancer
___ Cataracts
___ Chemical dependency
___ Chickenpox
___ Diabetes
___ Emphysema
___ Epilepsy
___ Fractures
___ Glaucoma
___ Goiter
___ Gonorrhea
___ Gout
___ Heath disease
___ Hepatitis
___ Hernia
___ Herpes
___ High cholesterol
___ HIV Positive
___ Kidney disease
___ Liver disease
___ Measles
___ Migraine headaches
___ Miscarriage
___ Mononucleosis
___ Multiple sclerosis
___ Mumps
___ Osteoporosis
___ Pacemaker
___ Pneumonia
___ Polio
___ Prostrate problems
___ Prosthesis
___ Psychiatric care
___ Rheumatoid arthritis
___ Rheumatic fever
___ Scarlet fever
___ Sexually transmitted infection(s)
___ Stroke
___ Suicide attempt
___ Thyroid problems
___ Tonsillitis
___ Tuberculosis
___ Tumors/growths
___ Typhoid fever
___ Ulcers
___ Vaginal infections
___ Whooping cough
___ Other: _____

Medications and Supplements

Do you take: ___Muscle relaxers ___Pain killers ___Anti-inflammatory ___Insulin ___Birth control ___Over-the-counter meds

List allergies to any medications/supplements: _____

List all medications you are currently taking:	List vitamins, herbs, minerals, over-the-counter meds: