SWEAT CHIROPRACTIC CLINIC
PATIENT REGISTRATION FORM

Today's Date_____

It is important that you answer all of the questions that apply to you to the best of your knowledge. If you have any questions or need assistance, please let the Receptionist know. Thank you!

Last Name _____ (name you want to be called by) _____
First Name and Initial _____ Date of Birth_____ Sex_____
Street Address _____ City/State/Zip _____
Home Phone _____ Hours you can be reached_____ Age____ Ht_____ Wt_____
If no home phone, please give a number where we can leave a message or contact your family.
_____SS#_____ # of children_____ Marital Status S M D W (circle)

Person responsible for payment of the account_____
(If insurance please give card to Receptionist)
Address and Telephone if different from Patient _____
Date of Birth_____ SS# _____
Patient's or Responsible party's Occupation _____ Work Phone _____
Employed by_____ Address_____
Name of Spouse _____ SS#_____ Occupation _____
Employed by _____ DOB _____ Work Phone _____

Please tell us how you heard about our Office? _____
If a friend or family member referred you, give us their name and address where we can thank them for recommending our services.

IS THIS VISIT DUE TO AN ACCIDENT? ( ) yes ( ) no If yes, Date of Accident_____
Type of Accident ( ) Auto ( ) Work Related ( ) Home ( ) Other _____

I prefer to handle my account ( ) Cash/Check ( ) Assignment of Insurance Benefits
( ) Charge Card Name of Card _____

Please list all medications you are currently taking_____
_____

Are you wearing ( )Heel lifts ( )Sole lifts ( )Inner soles ( )Arch supports ( )Dentures ( )Artificial limb
To your knowledge, have you any metal in your body ex: surgical wire, implants, metal fragments that have not been removed? ( ) yes ( ) no

Have you been in an auto accident? ( ) Past year ( ) Past 5 years ( ) Over 5 years ( ) Never
Have you had any other personal injury or accident? ( ) Past year ( ) Past 5 years ( ) Over 5 years
( ) Never Briefly describe: _____

Been knocked unconscious? ( ) yes ( ) no Explain:_____
Used a cane, crutch, etc…? ( ) yes ( ) no _____
Been treated for a spine disorder? ( ) yes ( ) no _____
Had a fractured bone? ( ) yes ( ) no _____
Been hospitalized for other than surgery? _____

Have you ever had Chiropractic care before? ( ) yes ( ) no
If yes, Name of Doctor_____ Treated for _____
Results _____ Were you satisfied with your care? ( ) yes ( ) no