Carrion Chiropractic Clinic
4500 E. Speedway, Ste. 77
Tucson, AZ 85712
(520) 319-1234

REGISTRATION

Date__________ Home Phone__________

Patient__________ (Last Name / First Name / Initial)

Street Address__________

City__________ State__________ Zip__________

Sex ☐ M ☐ F Age______ Birthdate__________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #__________ Driver's License #__________

Insured's Name__________ (Last Name / First Name / Initial)

Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other Condition Related to ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER

Company Name__________ Occupation__________

Address__________ Phone__________

City__________ State__________ Zip__________

SPOUSE

Name__________ (Last Name / First Name / Initial)

Birthdate__________ Social Security #__________

Employer Name__________ Occupation__________

Address__________ Phone__________

City__________ State__________ Zip__________

PATIENT INSURANCE INFORMATION

Please ✓ any and all insurance coverage you or your spouse has applicable in this case.

☐ MEDICARE ☐ BLUE SHIELD ☐ AUTO ACCIDENT
☐ MEDICAID ☐ MAJOR MEDICAL ☐ UNION PLAN
☐ BLUE CROSS ☐ WORKER'S COMPENSATION ☐ OTHER

BCBS I.D. # __________

MEDICARE/MEDICAID I.D. # __________

MAJOR MEDICAL OR AUTO INSURANCE Date of accident__________

Insurance Company Name__________ Adjuster__________

Address/Phone__________ Claim #__________

Policy #__________ Effective Date__________

SPOUSE CO-INSURANCE INFORMATION

MAJOR MEDICAL ONLY

Insurance Company Name__________

Address/Phone__________

Policy #__________ Effective Date__________

PATIENT AGREEMENT

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with__________ (Name of Insurance Company)

and assign directly to Dr.__________ 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.

__________ Signature of Insured/Guardian __________ Date

LEGAL INFORMATION

Family Physician__________

Person to contact in emergency (Name and Phone#):

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PRESENT COMPLAINTS

- ☐ HEADACHE
- ☐ HEAD SEEMS TOO HEAVY
- ☐ HEAD & SHOULDERS TIRED & HEAVY
- ☐ MENTAL DULLNESS
- ☐ LOSS OF MEMORY
- ☐ EQUILIBRIUM PROBLEMS
- ☐ DIZZINESS
- ☐ FAINTING
- ☐ TREMORS
- ☐ PALPITATION
- ☐ NECK PAIN
- ☐ NECK STIFFNESS
- ☐ NECK MOTION RESTRICTED
- ☐ UPPER BACK PAIN/STIFFNESS
- ☐ MID BACK PAIN/STIFFNESS
- ☐ LOW BACK PAIN/STIFFNESS
- ☐ PINS & NEEDLES IN ARMS/LEGS
- ☐ NUMBNESS IN FINGERS, ARMS, LEGS
- ☐ CHEST PAIN
- ☐ SHORTNESS OF BREATH
- ☐ EYE STRAIN
- ☐ PAIN BEHIND EYES
- ☐ EYES SENSITIVE TO LIGHT
- ☐ EYES LOSS OF FOCUS
- ☐ DOUBLE VISION
- ☐ EARS BUZZING/RINGING
- ☐ LOSS OF TASTE
- ☐ LOSS OF SMELL
- ☐ SINUS TROUBLE
- ☐ EXTREME NERVOUSNESS
- ☐ TENSION
- ☐ IRRITABILITY
- ☐ ANXIETY
- ☐ EXTREME FATIGUE
- ☐ INSOMNIA
- ☐ NEURITIS
- ☐ FACE FLUSHED
- ☐ FACE PALE
- ☐ EXCESS PERSPIRATION
- ☐ DIGESTIVE DISORDERS
- ☐ NAUSEA, VOMITING
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ DEPRESSION
- ☐ SWOLLEN ________
- ☐ FEET/HANDS COLD
- ☐ DIFFICULTY IN PROLONGED CAR-RIDING

☐ DIFFICULTY IN EXCESSIVE ☐ STANDING ☐ WALKING ☐ RIDING ☐ BENDING

☐ NECK, LOW BACK PAIN & STIFFNESS UPON RISING.

☐ PAIN RADIATING INTO ☐ RIGHT ARM ☐ RIGHT LEG ☐ BOTH ☐ LEFT LEG ☐ LEFT ARM ☐ BOTH

☐ DIFFICULTY IN EXCESSIVE LIFTING. ☐ LIGHT, ☐ MODERATE ☐ HEAVY ☐ REPETITIVE

☐ PAIN RADIATING INTO ☐ NECK ☐ BASE OF SKULL ☐ SHOULDER ☐ ARMS ☐ HIPS ☐ LEGS

DID YOU REQUIRE POST-ACCIDENT HOSPITALIZATION? ☐ YES ☐ NO IF SO, WHERE? ________

HAVE YOU HAD SIMILAR ACCIDENTS OR INJURIES BEFORE? ☐ YES ☐ NO

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE LAST YEAR? ☐ YES ☐ NO ________

DESCRIBE CONDITION ________ DATE OF LAST PHYSICAL EXAM ________

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ YES ☐ NO WHAT KIND? ________

ARE YOU TAKING ANY MEDICATION? ☐ YES ☐ NO WHAT KIND? ________

ARE YOU PREGNANT? ☐ YES ☐ NO DATE OF LAST MENSTRUAL PERIOD ________

Please list your symptoms below and the relative pain intensity (0 – 10) for each symptom.

No Pain		Mild			Moderate		Severe		Unbearable	
0	1	2	3	4	5	6	7	8	9	10

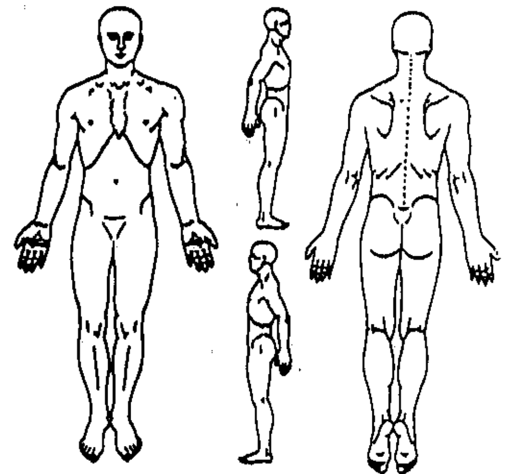
Symptoms: (*Example: Low back pain – 4*)

1) ________ 2) ________

3) ________ 4) ________

Please mark on the diagram to the right the following symbols as they relate to your symptoms:

SS= spasms ST= stiffness DP= dull pain SP= sharp pain
SH= shooting pain TI= tingling NU= numbness O= Other



Office Notes

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