

# Dr. David Yoshida A Chiropractic Corporation REGISTRATION FORM

(Please Print)

Today's Date \_\_\_\_\_

## PATIENT INFORMATION

Patient's Last Name		First	Middle		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.
Social Security	Birth Date	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
Street Address		City	State	Zip	Home Phone No.
E-Mail					Cell Phone No.
Occupation	Employer				Work Phone No.
Employee Address					Employer Phone No.
Spouse's Name			Social Security		Birth Date
Occupation	Spouse's Employer			Work Phone No.	

Whom may we thank for referring you?

## IN CASE OF EMERGENCY, CONTACT

Name	Relationship
Home Phone No.	Cell Phone No.

## INSURANCE INFORMATION

Name of Insurance Company		Insurance Company Address			
Subscriber's Name	Subscriber's SSN	Birth Date	Group #	Policy #	
Patient's Relationship to Subscriber : <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of Secondary Insurance (if applicable)		Subscriber's Name	Group #	Policy #	
Patient's Relationship to Subscriber : <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

## ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No      Date \_\_\_\_\_

Type of Accident  Auto  Work  Home  Other

To whom have you made a report of your accident?  Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_ Phone No. \_\_\_\_\_

## PATIENT CONDITION

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

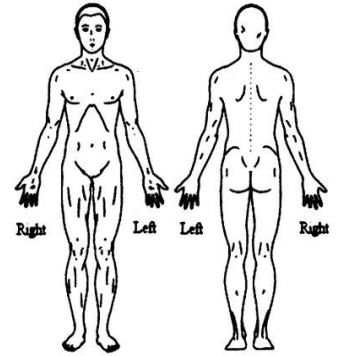
How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

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

Height \_\_\_\_\_ Weight \_\_\_\_\_



## HEALTH HISTORY

What treatment have you already received for you condition?  Medications  Surgery  Physical Therapy  Chiropractic Services  
 None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for you condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_ Spinal Exam \_\_\_\_\_  
 Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_ Dental X-Ray \_\_\_\_\_ MRI, CT/Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |                               |  |                    |  |                    |  |
|-------------------------------|--|--------------------|--|--------------------|--|
| AIDS/HIV                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psycho Emotional   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Problem            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Disorder                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Brain Fog                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Problems           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Disorders                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Implants/<br>Reduction | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headache           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dependency                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whopping           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chicken Pox                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cough              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Disease            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____        |  |
| Emphysema                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve      | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____              |  |
| Epilepsy                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia          | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____              |  |
| Goiter                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio              | <input type="checkbox"/> Yes <input type="checkbox"/> No |                    |  |
|                               |  | Prostate Problem   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                    |  |

<b>EXERCISE</b> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<b>WORK ACTIVITY</b> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<b>HABITS</b> <input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Coffee/Caffeine Drinks <input type="checkbox"/> High Stress	Packs/Day _____ Drinks/Week _____ Cups/Day _____ Reason _____
---	---	--	--

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS / HERBS / MINERALS
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____

Pharmacy Name \_\_\_\_\_ Pharmacy Phone No. \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. David F. Yoshida. I understand that I am financially responsible for any and all balance(s). I also authorize Dr. David F. Yoshida A Chiropractic Corporation to release any information pertinent to my case to my insurance company, adjuster or attorney involved in my case.

X \_\_\_\_\_  
 PATIENT/GUARDIAN SIGNATURE DATE