FLEETWOOD CHIROPRACTIC & WELLNESS CENTER P.C.

8520 Allentown Pike #7, Blandon, PA 19510
(610) 916-2425

PATIENT REGISTRATION

NAME_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

DOB_____ Age_____ MARITAL STATUS_____

SS #_____ GENDER_____

Cell #_____ Home #_____

Work #_____

Email_____

If under 18 years old

GUARDIAN'S NAME_____

ADDRESS_____

CITY_____ STATE_____ZIP_____

DOB_____ Email _____

INSURANCE PRIMARY_____
ID#_____ Group#_____
Guarantor_____ DOB _____
INSURANCE SECONDARY _____
ID#_____ Group# _____
Guarantor_____ DOB _____

Please present insurance card(s) to front desk to copy for your file.

Correspondence Consent; ***Email____*** ***Text____*** *Detailed message on Phone____*

How did you hear about us? _____

PRIVACY: Is there anyone who we can share your medical information with? If so, please list below.

Name	**Phone#**	**Relationship**

*******PLEASE PROVIDE YOUR PRIMARY CARE PHYSICIAN INFORMATION:**

NAME: _____
ADDRESS: _____
OFFICE TELEPHONE NUMBER: _____

Is your condition today related to;

- ☐ **Motor Vehicle Accident**
- ☐ **Workers Compensation**
- ☐ **Personal Injury Case**
- ☐ **None of the Above**

Name_____

DOB_____

Date of Injury_____ State MVA occurred_____

Insurance Information

Insurance Name_____

Address_____

Claims Address_____

Contact Name_____

Phone number_____

Claim #_____

Is your claim open and compensable? _____

Please be advised we will bill to your insurance company on your behalf for all treatments and services rendered at Fleetwood Chiropractic and Wellness Center, P.C. You are responsible for any amounts not covered by your insurer.

Signature_____ Date_____

NAME_____ **DATE**_____

Current Complaints/ Symptoms	**Complaint/ Symptom Associated with:** (e.g., accident, injury, medical condition, unknown) **Please Specify**	**Pain or discomfort Level:**	**Times or Situations at/in which pain is at its worst** (e.g., am., pm., during sleep, with activity, sitting, standing,)	**Areas of life impacted by Pain/Discomfort** (e.g., work, sleep, daily routine, recreation, exercise)
1.		0 1 2 3 4 5 6 7 8 9 10		
2.		0 1 2 3 4 5 6 7 8 9 10		
3.		0 1 2 3 4 5 6 7 8 9 10		

Are you Currently Pregnant? __ Yes __ No
If yes, Due Date_____ Any Complications? _____

List all Medications you are currently taking; _____

_____

_____

_____

_____

_____

_____

_____

NAME_____ **DATE**_____

Medical History (check all that apply)

	No Medical Problems		Peripheral Vascular Disease
	DEXA scan or bone density scan		Hiatal Hernia/ Reflux Disease
	History of MRSA		Peptic Ulcer Disease
	Claustrophobic or fearful of enclosed spaces		Diverticulitis
	Diabetes, Insulin-Requiring		Urinary Tract Infections
	Diabetes, Non-Insulin Dependent		Kidney Disease
	Bleeding Disorder		High Cholesterol
	Pulmonary Embolism (Blood Clot- Lung)		Osteoporosis
	Deep Vein Thrombosis (Blood Clot- Leg)		Fibromyalgia
	Thyroid Disease		Seizure Disorder
	HIV or AIDS		Gout
	Leukemia or Lymphoma		Osteoarthritis
	Organ Transplant		Rheumatoid Disease
	Migraine Headaches		Cancer
	Heart Arrhythmia		Hepatitis
	Pacemaker		Liver Disease
	Heart Murmur		Psoriasis or other Skin Disease
	Stroke or Mini- Stroke		Poliomyelitis
	High Blood Pressure		Anxiety Disorder
	Asthma		Depression
	Emphysema or COPD		Alcoholism or Drug Addiction
	Pneumonia		Psychiatric Disorder
	Tuberculosis		Glaucoma
	Sexually Transmitted Disease		Eating Disorder
	Multiple Sclerosis		Parkinson's Disease
	Dementia (such as Alzheimer's Disease)		Prosthesis

Please list any other conditions not mentioned above:

_____

_____

Height_____ **Weight**_____

Allergies: Please list all meds, metals, dyes, latex, or food

_____

_____

Occupational History;

__retired __working __unemployed __ homemaker __ paid leave __ unpaid leave __ disabled

Employer_____
Occupation_____**# of years**_____
If not working previous occupation _____ **# of years**_____

NAME_____ **DATE**_____

Family History

	No Medical Problems		Peripheral Vascular Disease
	Asthma		Heart Disease
	Back Problems		High Blood Pressure
	Cancer		Diabetes

Surgical History			**Date and Details**
	No Previous Surgeries		
	Fracture without Surgery		
	Fracture with Surgery		
	Shoulder Surgery		
	Hand Surgery		
	Spine Surgery		
	Total Hip Arthroplasty		
	Total Knee Arthroplasty		
	General Surgery		
	Appendectomy		
	C-Section		
	Gallbladder		
	Hernia Repair		
	Tonsillectomy/Adenoidectomy		
	Wisdom Teeth Extraction		
	Other		

Social History

	Marital Status		
	Number of Children		
	Tobacco use		
	Nicotine Vapor use		
	Alcohol use		
	Steroids		
	Caffeine		
	Recreational Drugs		
	Exercise		