REGISTRATION

Confidential Patient Information

BACKSMITH CHIROPRACTIC, Lucas J. Smith, DC, DACBSP
1878 East Wyandot Ave, Suite A1, Upper Sandusky, OH 43351
Phone (419)731-4229 Fax (419)731-4157

Patient Name:___________________________________ Chief Complaint:_______________________________

Address:____ Home Phone:__________________________________
City:________________________ Zip:________________ Cell Phone:____________________________________
SS#:____ Email:____
Date of Birth:___________________________________ Marital Status: M S W D
Occupation:_____________________________________ Employer:_____________________________________
Address of Insured (if different than above):____

Are your present symptoms or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ____Yes ____No

Insurance Company:_________________________________ Insurance Phone #:_______________________________
ID#____ Group #____
Name of Policy Holder_______________________________ Policy Holder DOB_______________________________
Policy Holder Employer____

Family Physician_______________________________ (May we send your health information to this provider Y / N)

Person to Contact in case of emergency (Name & Phone)____

Have you ever been under Chiropractic care? Y / N If so, who?____

Have you had: X-RAY / MRI / CT in the last year? If so, where?____

What operations have you had?____When?________________

Serious Illness/Infectious Disease:____When?________________

Do you have a pacemaker? Y / N Do you have any Shoulder, Hip, Knee Replacements? Y / N ________________

What medications are you taking? ___Pain Killers ___Insulin ___Cholesterol ___Blood Pressure ___Muscle Relaxers
___Birth Control Other:____

What is your goal in our office?____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care coverage with the above captioned, and hereby assign at physician's request, and convey directly to Dr. Smith, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor any and all plan documents, insurance policies and/or settlement information upon written request from such doctor in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor in any attempts by such doctor to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor against such insurers and/or employee health care plan in my name but at such doctor expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered valid as original. I have read and understand this agreement.

____ ___________________________
Signature of Insured/Guardian Date

CASE HISTORY

BACKSMITH CHIROPRACTIC
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This box will be completed by our Office Staff:	HT:__________ WT:__________lbs. BP________/_______ PR _______bpm

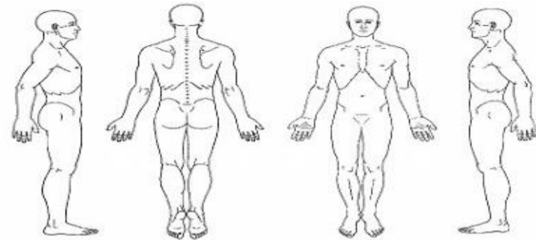
1. **Please List your condition** **Circle the Severity of Pain** **Circle the Frequency of Pain**

Condition/Problem	Severity (Minimal – Severe)	Frequency (% of time) (Occasional – Constant)
a. ________________________________	0 1 2 3 4 5 6 7 8 9 10	10 20 30 40 50 60 70 80 90 100
b. ________________________________	0 1 2 3 4 5 6 7 8 9 10	10 20 30 40 50 60 70 80 90 100
c. ________________________________	0 1 2 3 4 5 6 7 8 9 10	10 20 30 40 50 60 70 80 90 100
d. ________________________________	0 1 2 3 4 5 6 7 8 9 10	10 20 30 40 50 60 70 80 90 100

2. Symptoms are worse in the: **(Circle what applies)**

   - Morning - Increase during the day
   - Afternoon - Same all day
   - Night -Decrease during the day

Please mark the regions of pain



3. Describe your Symptom: **(Circle what applies)**

   Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

4. When did your symptoms begin (onset date)? ____
5. How did your symptoms begin? ____
6. Has your condition: ____ Improved ____ Worsened ____ Stayed the same
7. Have you ever experienced this before? ____Yes ____No
8. Do your symptoms radiate? ____Yes ____No
9. What makes your condition worse: **(Circle what applies)**

   Bending / Lifting / Movement / Running / Standing / Sitting / Sleeping / Twisting / Walking / Working

10. Does anything relieve the pain? ___Yes ___ No Describe: ______________________________
11. If No, what have you tried? ____
12. Have you been treated for this before? ___Yes ___No How long ago? ____________________
13. What treatment did you receive? ____
14. Results of previous treatment? ____ Good ____ Poor Comments _________________________
15. Were you referred to our office by anyone? ____
16. List any major Injuries or Surgeries: ____
17. List any Medications or Supplements you are taking: _________________________________
18. Any other Musculoskeletal Problems ___Yes ____No …Neurological Problems ____Yes ____No

_____ Additional Information on the back

I certify the above information is accurate to the best of my knowledge.

Signature ____ Date ______________________