Patient Registration

Mr. Miss Mrs. Ms. Dr. Sep

Last Name: First: Middle: Marital Status: Single Mar Div Wid Part

Gender: M F

Birth Date: / /

Age: SSN: E mail Address:

Address: Address (2):

City: State: Zip:

Phone Number: ( )

Mobile Number: ( )

Fax Number: ( )

Occupation: Employer: Work Number: ( )

Office Use

Chart:

Date:

Entered

Entered By:

Contacting You

May we call you? Yes No

May we e mail you? Yes No

May we mail you? Yes No

How did you hear about our weight loss program?

Billboard Coupon Direct Mailing Employee Internet M.D./Doctor Magazine
Newspaper Patient/Friend Radio T.V. Walk In Other:

Do you know anyone else at Standridge Chiropractic If so, who?

Which doctor, if any, referred you?

Emergency Contact

Local Friend/Relative: Relationship: Phone Number: ( ) Work Number: ( )

Insurance Information

Medical insurance policies do not typically cover weight management care and related expenses, including laboratory testing, electrocardiograms, prescription medication and related supplements. If your primary diagnosis is obesity, you may not bill your insurance company for a co morbid condition. Doing so may result in a charge of fraud against you and/or the physician.

An appropriate receipt of payment will be provided, including a charges and descriptions of the office visit for the different levels of service provided. The codes used for this purpose may or may not correspond to the codes used by insurance companies.

Changes to "codes" will not be made for the use of any insurance company. Insurance companies may reimburse patients for expenses related to weight management, for instance if co morbid conditions are also part of the weight management treatment, but reimbursement will not be made from the insurance company to the physician. Again, please understand that **Standridge Chiropractic**will not present a bill to any insurance company for weight management services or related charges. Also, **Standridge Chiropractic** will provide what is considered an appropriate receipt, as above described and is not obligated to complete any form that may be provided by a health insurance company sent to the patient or physician in this regard.

If you are covered by MEDICARE INSURANCE you must complete and sign an informed waiver prior to participation in this Weight Management Program.

Medicare Beneficiary

Are you currently a beneficiary of Medicare? Y N

Supplement Key Chain Pill Fob

We may provide a supplement key chain pill container as part of a new patient starter kit or as separately sold item. This container is not approved or appropriate for storing controlled substances, such as prescribed medications. All prescribed medications must remain in their originally labeled bottle.

Patient Statement of Understanding

I have read and fully understand the above information related to insurance and participation in **Standridge Chiropractic** weight loss program. I have also had the opportunity to ask questions regarding these issues. I am aware that I will receive an appropriate receipt of payment for my personal use as I see fit to do so. I understand the specifics of these receipts and limitations as described in this document. I accept these specific policy rules.

Patient/Guardian Signature: Date:

Printed Name: If you are a guardian, what is your relationship to the patient?

Standridge Chiropractic Patient History

Chart:

Date:

Revisions:

Office Use

All questions contained in this history form are strictly confidential and will become part of your medical record on file.

Last Name: First Name: Middle: Gender: M F Birth Date: / / Age:

Primary Physician/Referral: Physician Phone Number: ( )

Optometrist/Ophthalmologist: Ophthalmologist Phone Number: ( )

Weight:

Last Physical: Last EKG: Last Eye Exam:

Goal Weight:

Health History

Complete to the best of your knowledge.

	Famil	Person		Famil	Person		Famil	Person
Alcohol Abuse			Dizzy Spells			Irregular Pulse		
Anemia			Drug Abuse			Kidney Disease		
Arthritis			Eating Disorder			Liver Disease		
Asthma			Epilepsy			Lung Disease		
Bleeding Disorder			Fainting Spells			Mental Illness		
Bloody Stool			Fatigue			Migraines		
Bronchitis			Frequent Urination			Moodiness		
Cancer			Gallbladder Disorder			Nervousness		
Chest Pain			Glaucoma			Obesity		
Constipation			Headaches			Palpitations		
Convulsions			Heart Disease			Rashes		
Depression			High Cholesterol			Shortness of Breath		
Diabetes			Hypertension			Stroke		
Diarrhea			Insomnia			Thyroid Disease		

Comments/Other:

Surgeries & Other Hospitalizations

Year	Reason / Diagnosis	Hospital

Medication Allergies

Medication Name	Reaction

Prescribed Medications & Over the Counter drugs, dietary supplements (including vitamins, inhalers, etc)

Medication Name	Strength	Frequency

Behavior Style *Please select only one answer.*

You are always calm and easygoing.	You are usually calm and easygoing.	You are sometimes calm and easygoing
You are seldom calm and persistently driving for advancement	You are never calm and have overwhelming ambition	You are hard driving and never relax.

Health Habits & Personal Safety *This section is optional. All answers will be kept strictly confidential.*

Exercis	Sedentary (no exercise)				
	Mild Exercise (i.e., climbing stairs, walking three blocks, golf)				
	Occasional vigorous exercise (i.e., work or recreation less than 4 times per week for 30 minutes)				
	Regular vigorous exercise (i.e., work or recreation 4 times per week or more for 30 minutes or more)				
Die	Are you dieting?			Yes	No
	If yes, are you on a physician prescribed medical diet?			Yes	No
	How many meals do you eat in an average day?				
	Rank your salt intake:		High	Medium	Low
	Rank your fat intake:		High	Medium	Low
Caffein	Rank your caffeine intake:	High	Medium	Low	None
	What types of caffeine do you drink?	Coffee	Tea	Soda	
	How many cups/cans per day?				
Alcoh	Do you drink alcohol?			Yes	No
	If yes, what kind?		Beer	Liquor	Wine
	How many drinks per week?				
Tobacc	Do you use tobacco?			Yes	No
	Cigarettes - packs/day:	Chew - #/day:	Pipe - #/day:	Cigars - #/day:	
	How many years?				
	If you previously used tobacco, what year did you quit?				
Dr	Do you currently use recreational or street drugs?			Yes	No
	Have you ever taken street drugs with a needle?			Yes	No
Se	Are you sexually active?			Yes	No
	If yes, are you trying for a pregnancy?			Yes	No
	If you are not trying for a pregnancy, what contraceptive methods are you using?				

Women Only

How old were you at onset of menstruation?	Date of last menstruation?	
How often do you get your period (days)?	Number of Pregnancies:	Number of live births:

Heavy periods, irregularity, spotting, pain, or discharge?	Yes	No
Are you pregnant, trying for pregnancy, or breast feeding?	Yes	No

Weight History	
1.	What is the main reason you decided to lose weight?
2.	When did you begin gaining excess weight (give reasons if known)?
3.	What do you think is the main cause of your weight problems?
4.	Describe your previous attempts at weight loss or previous diets you have followed. Give dates and results if possible.
5.	Is your spouse, fiancé, or partner overweight?
6.	How often do you dine out? What restaurants do you frequent? What types of food do you eat there?
7.	List any food allergies:
8.	What foods do you avoid?
9.	What foods do you crave?
10.	Do you awaken hungry during the night?
11.	What are your worst food habits?
12.	What are your snack habits?
13.	Rate your body from 1 to 10. How would you describe your body?
14.	If you could change one thing about your body, what would it be?
15.	What do you feel will be your obstacle(s) to successful weight loss?
16.	What is your typical breakfast? What time? Where? With whom?
17.	What is your typical lunch? What time? Where? With whom?
18.	What is your typical dinner? What time? Where? With whom?
19.	Add any additional comments you think would be helpful to the doctor.

Accuracy Agreement	
I hereby agree that the information contained in this medical history is accurate to the best of my knowledge.	
Signature:	Date:

Thank You.

This information will assist us in establishing your medical history and identifying problem areas. Thank you for your time and patience in completing this form.