CHIROPRACTIC REGISTRATION AND HISTORY

Dr. Richard S. Cheung

424 N. Lake Ave Suite 104
Pasadena, CA 91101
(626) 398-3838

PATIENT INFORMATION

Date

DOB

Email

SSN

Phone #1

Name

Phone #2

Address

Occupation

City

Zip

Employer

○ Female ○ Male ☐ Single ☐ Widowed ☐ Divorced ☐ Married ☐ Separated

Emergency Contact Person

Their Phone Number

Who were you referred by?

INSURANCE

Insurance Company

Group Number

Primary person on account

Relationship to patient

Is the patient covered by additional insurance? ○ Yes (fill out fields below) ○ No

Insurance Company

Group Number

Primary person on account

Relationship to patient

Primary person DOB

Primary person SSN

ASSIGNMENT & RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with

& assign directly to Dr. Richard S. Cheung all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

PAIN CONDITION

Reason for your visit

When your symptoms started

This condition has been...

- ◯ Getting better
- ◯ Getting worse
- ◯ About the same

Activities or movements that are painful to perform:

- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Bending
- ☐ Lying Down

Type of pain (check all that apply)

- ☐ Sharp
- ☐ Dull
- ☐ Throbbing
- ☐ Burning
- ☐ Tingling
- ☐ Cramps
- ☐ Numbness
- ☐ Aching
- ☐ Shooting
- ☐ Stiffness
- ☐ Swelling
- ☐ Other

How often do you have this pain?

Your pain is...

- ☐ Constant
- ☐ Comes and goes

Your condition interferes with...

- ☐ Work
- ☐ Sleep
- ☐ Recreation
- ☐ Daily routine

What treatment(s) have you already received for your condition?

- ☐ Medications
- ☐ Surgery
- ☐ Physical Therapy
- ☐ Chiropractic
- ☐ Something else
- ☐ None of these

Rate the severity of your pain on a scale of 1 to 10:

1 = least pain
10 = severe pain

ACCIDENT INFORMATION

Is your condition accident related?

◯ Yes ◯ No

** If yes, please inform our staff for additional paperwork. **

Type of accident:

- ☐ Auto
- ☐ Work
- ☐ Home
- ☐ Other

Date of accident

To whom have you made a report of your accident?

- ☐ Auto Insurance
- ☐ Employer
- ☐ Worker Comp
- ☐ Other

PATIENT HEALTH HISTORY

Do you have or have had any of the following conditions?

GENERAL

- [ ] Alcoholism
- [ ] Anemia
- [ ] Cancer
- [ ] High cholesterol
- [ ] Diabetes
- [ ] Epilepsy/seizures
- [ ] Thyroid
- [ ] Gout
- [ ] Hypoglycemia
- [ ] Osteoarthritis
- [ ] Parkinson's Disease
- [ ] Pneumonia
- [ ] Polio
- [ ] Rheumatic fever
- [ ] Rheumatoid arthritis
- [ ] Depression
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Skin disorders

RESPIRATORY

- [ ] Chest pain
- [ ] Coughing up blood
- [ ] Difficulty breathing
- [ ] Shortness of breath
- [ ] Allergies
- [ ] Chronic cough
- [ ] Spitting up phlegm
- [ ] Emphysema

URINARY TRACT

- [ ] Blood in urine
- [ ] Cannot control
- [ ] urination
- [ ] Painful urination
- [ ] Bladder infection

GASTROINTESTINAL

- [ ] Problem with gallbladder
- [ ] Liver trouble / Hepatitis
- [ ] Excessive thirst
- [ ] Distress from greasy foods
- [ ] Pain over stomach
- [ ] Excessive burping
- [ ] Bloating (where?)
- [ ] Mucus in stool
- [ ] Colitis
- [ ] Hiatal hernia
- [ ] Vomiting
- [ ] Constipation
- [ ] Burning in stomach relieved by eating

NERVOUS SYSTEM

- [ ] Dizziness/lightheadedness
- [ ] Fainting
- [ ] Discoordination
- [ ] Memory loss

FOR WOMEN

- [ ] Irregular periods
- [ ] Hot flashes
- [ ] Vaginal discharge
- [ ] Menopausal symptoms
- [ ] Headaches with period
- [ ] Menstrual cramps
- [ ] Excessive flow
- [ ] Hysterectomy
- [ ] Premenstrual depression
- [ ] Painful breasts
- [ ] Lumps in breasts

RESISTANCE TO INFECTION

- [ ] Catch colds easily
- [ ] Frequent sinus trouble
- [ ] Frequent influenza

EYE, EAR, NOSE & THROAT

- [ ] Vision problems
- [ ] Hearing loss
- [ ] Ear pain
- [ ] Ear noises
- [ ] Dental problems
- [ ] Nose bleeds
- [ ] Difficulty breathing through nose
- [ ] Difficult speech
- [ ] Hoarseness
- [ ] Sore throat

NEUROMUSCULOSKELETAL

- [ ] Headaches
- [ ] Upper extremity pain
- [ ] Lower extremity pain
- [ ] Neck pain
- [ ] Low back pain
- [ ] Tingling in hand or feet

FOR MEN

- [ ] Burning on urination
- [ ] Prostate trouble
- [ ] Need to get up at night to urinate
- [ ] Difficulty starting urine
- [ ] Dripping after urination
- [ ] Feeling of incomplete bowel evacuation

BLOOD SUGAR

- [ ] Irritable before meals
- [ ] Get shaky if hungry
- [ ] Lightheaded if meals delayed
- [ ] Fatigue is relieved by eating
- [ ] Abnormal cravings for sweets/snacks
- [ ] Moods of depression – "the blues"
- [ ] Heart palpitates if meals are missed/delayed
- [ ] Awaken after a few hours of sleep, difficult to get back to sleep

Any other conditions not listed, please mention:

____

PATIENT HEALTH HISTORY

Complete any that apply.

☐ Coffee/Caffeine
____ cups per day

☐ Alcohol
____ drinks per week

☐ Smoking
____ packs per day

☐ High stress

☐ Recent weight gain or loss

How many times a day do you eat?

How is your quality of sleep?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

How would you describe your current health?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

Are you following a special diet?

- ○ No
- ○ Yes

Last physical exam

Last MRI, CT-Scan, or Bone Scan

Medications

Vitamins, herbs & supplements

Allergies

Any past accidents? *Car accidents, falls, head injuries, fractures, dislocations, etc*

Any past surgeries?

What do you do for exercise?

PATIENT SIGNATURE

Patient Signature

Date