CHIROPRACTIC
LAKE MERIDIAN
P.S.

PATIENT REGISTRATION FORM

Name _____MI _____ Last Name _____

Preferred Name _____

DOB _____

Email_____

Address _____

City _____State _____Zip _____

Cell Phone _____ Home Phone _____

Marital Status: ____ Single ____Married ____Separated ____Divorced ____Widowed

How did you hear about us? ___Doctor ___Friend ___Family Member ___Insurance Book ___Friend
___Website ___Social Media ___Other_____

Whom may we thank for referring you? _____

Primary Care Physician _____

Phone_____

Employment Status: ___Full-Time ___ Part-Time ___Self Employed ___ None ___Disabled ___Student

Patient's Employer _____Work Phone _____

Address _____

City _____State _____Zip _____

CHIROPRACTIC
LAKE MERIDIAN
P.S.

Emergency contact name _____

Phone_____

Relationship _____

Address _____

City_____State_____ Zip_____

Minor Consent: I authorize Lake Meridian to provide treatment for the minor listed above.

Parent Guardian _____Signature_____

Primary Insurance Name:_____ ID # _____

Subscriber Name:_____

Relationship to Subscriber: _____Self ___Spouse ____Child

Secondary Insurance Name:_____ ID # _____

Subscriber Name:_____

Relationship to Subscriber: _____Self ___Spouse ____Child

CHIROPRACTIC
LAKE MERIDIAN
P.S.

Attorney's Name :_____

- Attorney's Phone # _____

Labor & Industries

- Date of Injury:_____ Claim # _____

Patient's Auto Insurance Name _____

- Phone #_____ Claim # _____

Other Driver Information: Name _____

- Address _____ City _____State _____Zip _____
- Drivers Ins. Co. _____
- Ins Co. phone # _____
- Claim # _____

Patient Signature_____

Date_____

CHIROPRACTIC
LAKE MERIDIAN
P.S.

Current Symptoms

Name_____ Date_____

Reason for today's visit is a result of:
____Work Accident ____Auto Accident ____Sport Accident

____Trauma ____Chronic ____Check Up

Have you ever been treated by a Chiropractor before? ____Yes ____No

Major Concerns:

1. _____

How Intense? (0-Least; 10-Worst) 0 1 2 3 4 5 6 7 8 9 10

How Frequent? (Rarely - All the time) 25% 50% 75% 100%

Interfere with Work, Sleep, Daily Routine? W S D

2. _____

How Intense? (0-Least; 10-Worst) 0 1 2 3 4 5 6 7 8 9 10

How Frequent? (Rarely - All the time) 25% 50% 75% 100%

Interfere with Work, Sleep, Daily Routine? W S D

3. _____

How Intense? (0-Least; 10-Worst) 0 1 2 3 4 5 6 7 8 9 10

How Frequent? (Rarely - All the time) 25% 50% 75% 100%

Interfere with Work, Sleep, Daily Routine? W S D

4. _____

How Intense? (0-Least; 10-Worst) 0 1 2 3 4 5 6 7 8 9 10

How Frequent? (Rarely - All the time) 25% 50% 75% 100%

Interfere with Work, Sleep, Daily Routine? W S D

When did this first become a concern for you?_____

_____

Have you ever experienced these symptoms before? ____Yes ____No

If Yes, when?_____

Have you been treated for these past episodes(s)? ____Yes ____No

If Yes, by whom? Chiropractor MD Osteopath Physical Therapist
Massage Therapist Other_____

Is a doctor currently seeing you? ____Yes ____No
If Yes, by whom?_____

Goals of Treatment _____

Are you taking any of the following medications?

___Nerve Pills ___Pain Killers (or aspirin) ___Muscle Relaxers
___Insulin ___Stimulants ___Blood Thinners
___Hormones ___Birth Control ___Other_____

Are you wearing: ___Heel Lifts ___Arch Supports

Are any of the following in your family history?

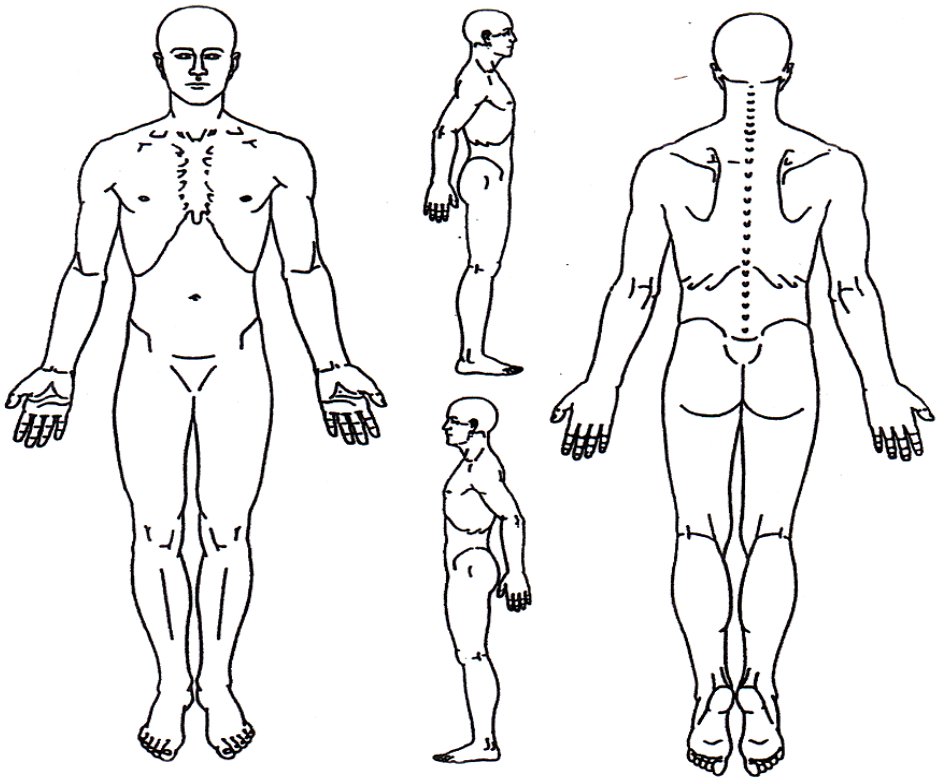
___Caner ___Scoliosis ___Stroke
___Diabetes ___Heart Disease ___Blood Disease
___Blood Disease ___Multiple Sclerosis ___Other_____

CHIROPRACTIC
LAKE MERIDIAN
P.S.

Indicate on the diagrams below the location/s and type of sensation/s you have been experiencing. Use the letters below to indicate the type of sensation. If the letters don't describe the sensation, write in your description of what you are feeling.

A - Ache	B - Burning	Co - Constrictive	C- Cramping	Cu- Cutting
D - Dull	N - Numbness	P - Pounding	S - Sharp	SH- Shooting
Sp - Spasm	St - Stinging	T - Tingling	TH - Throbbing	

O-Other_____



Recreational Activities:

Sports_____ How Often_____

Exercise_____ How Often_____

Hobbies_____ How Often_____

CHIROPRACTIC
LAKE MERIDIAN
P.S.

Surgeries (please list the surgery and the year it was done)

Accidents (pleases list brief description and the year it happened)

Fractures (please list what was fractured and the year it happened)

Medical Conditions (Circle all that apply):

Alcoholism	Eczema	Pneumonia	Small Pox
Allergies	Epilepsy	Polio	Tuberculosis
Anemia	Heart Attach	Rheumatic	Typhoid Fever
Appendicitis	Hemophilia	Fever	Whooping
Arthritis	Hepatitis	Scarlet Fever	Cough
Cancer	Kidney Disease	Scoliosis	Other_____
Chicken Pox	Liver Disease	Sexually	None
Depression	Mumps	Transmitted	
Diabetes	Pleurisy	Disease	

Cigarettes	None	Light	Moderate	Heavy	Amount_____
Alcohol	None	Light	Moderate	Heavy	Amount_____
Recreational Drugs	None	Light	Moderate	Heavy	Amount_____

Signature_____Date_____

NECK BOURNEMOUTH QUESTIONNAIRE

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS: _____

Patient Name _____ Patient Signature _____

Examinner _____ Date _____ Score _____ (70)

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short -form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

CHIROPRACTIC
LAKE MERIDIAN

Work Injury/Personal Injury Questionnaire

Please take a few minutes to fill out this form as completely as possible. If you have any questions, we will be glad to help you.

Date of Injury:_____/_____/_____ Time: _____ ☐AM ☐PM

Employer:_____

Location:_____ City: _____ State: _____

Please explain in detail how your injury happened:

Did you report injury to your foreman or employer? ☐Yes ☐No

Was an injury report filled out? ☐Yes ☐No

Name of supervisor injury was reported to: _____

Check off your symptoms right after and a few days following:

☐Headaches	☐Neck pain	☐Neck stiffness	☐Fainting	☐Ringing in ears
☐Loss of smell	☐Pain behind eyes	☐Dizziness	☐Nausea	☐Confusion
☐Fatigue	☐Tension	☐Irritability	☐Upper back pain	☐Mid back pain
☐Low back pain	☐Nervousness	☐Loss of taste	☐Toe/Foot numbness	☐Constipation
☐Cold hands	☐Cold feet	☐Diarrhea	☐Depression	☐Anxious
☐Chest pain	☐Sleeping pain	☐Shortness of breath	☐Other _____	

Since the injury, are you symptoms: ☐Improving ☐Getting worse ☐Same

Where did you go after the injury? ☐Home ☐Work ☐Hospital ER ☐Private Doctor ☐Other_____

Name of attending Doctor: _____

Location: _____ City _____ State _____ Zip_____

What treatments or medications did you receive? _____

_____

Are your work activities restricted as a result of this injury? ☐Yes ☐No Last day of work: _____

Did you return to work? ☐Yes ☐No Date: _____/_____/_____

Are you on light or modified duty? ☐Yes ☐No

If Yes, please describe your modified duties:

Please indicate which of the following tasks are included in your typical job prior to the injury and the frequency at which they were performed: Please mark with an "X"

	Never	*Seldom (0-1 hr)*	*Occasional (1-3 hrs)*	*Frequent (3-6 hrs)*	*Constant*
Sit					
Stand					
Climb (ladder/stairs)					
Twist					
Bend/Stoop					
Squat/Kneel					
Crawl					
Reach Left, Right, Both					
Work above shoulders L, R, B					
Keyboard L, R, B					
Wrist L, R, B					
Grasp (forceful) L, R, B					
Fine manipulation L, R, B					
Operate foot controls L, R, B					
Vibratory tasks, high impact					
Vibratory tasks, low impact					
**Lift L, R, B*	lbs.	lbs.	lbs.	lbs.	lbs.
**Carry L, R, B*	lbs.	lbs.	lbs.	lbs.	lbs.
**Push / Pull L, R, B*	lbs.	lbs.	lbs.	lbs.	lbs.

*If the job includes lifting, carrying or pushing/pulling, indicate in the box how many pounds you typically move.

Have you ever had a Workman's Compensation claim before? ☐Yes ☐No When?_____

Patient Signature _____ **Date** _____