

Patient Registration & History

Name _____ Date _____
SS# _____ - _____ - _____ Date of Birth _____ Age _____
Street Address _____ City _____ State _____ Zip Code _____
E-mail _____ Home Phone _____ Work Phone _____
Cell Phone _____ Sex: Male Female Marital Status: Single Married Divorced
Employer _____ Occupation _____
Spouse's Name _____ Ages of Children _____
Spouse's Employer _____ Occupation _____
In case of emergency, contact: Name _____ Relationship _____
Home Phone _____ Work Phone _____ Cell Phone _____
Whom may we thank for referring you? _____
Who is your primary care physician? _____

Insurance Information

Who is responsible for this account? _____ Relationship to Patient _____
Insurance Company _____ Insurance ID# _____
Subscriber's Name _____ SS# _____ - _____ - _____
Date of Birth _____ How payment will be made Cash Check Credit Card Other

Assignment & Release

I certify that I, and/or my dependent(s), have insurance coverage with _____
(name of insurance company(ies)) and assign directly to Dr. Travis R. Oller and Downtown Chiropractic all
insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially
responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all
insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-
named insurance company(ies) and their agents for the purpose of obtaining payment for services and
determining insurance benefits or the benefits payable for related services. This consent will end when my
current treatment plan is completed or one year from the date of signed below.

I hereby give permission to the professionals of Downtown Chiropractic for examination. I understand that
payment is due at the time of service unless other arrangements are made in advance.

Signature of Patient, Parent, Guardian, or Personal Representative

Relationship to Patient

Please print name of Patient, Parent, Guardian, or Personal Representative

Relationship to Patient

Patient Condition

Reason for visit _____

When did your symptoms appear? _____

Is this condition: Getting Worse Staying the Same Improving

Rate the severity of your pain on a scale of 1(little to no pain) to 10 (severe pain) _____

What percentage of the day do you have this pain? _____

Is the pain constant or does it come and go? _____

Does the pain interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending

Lying Down Other _____

Is condition due to an accident? Yes No Type of accident Auto Work Home Other

What type of treatment have you received for your condition? Medication Surgery Physical Therapy

Chiropractic Bed Rest None Other _____

Name(s) of any doctors who have treated you for this condition _____

Health History

Please mark any symptoms or conditions as listed below, noting whether you have had it in the past or presently have.

- | | | | | | | | |
|---------------------------------------------------|--------------------|---------------------------------------------------|---------------------|---------------------------------------------------|---------------------|---------------------------------------------------|----------------------|
| Past Present | | Past Present | | Past Present | | Past Present | |
| <input type="checkbox"/> <input type="checkbox"/> | AIDS/HIV | <input type="checkbox"/> <input type="checkbox"/> | Chemical Dependency | <input type="checkbox"/> <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> | Prosthesis |
| <input type="checkbox"/> <input type="checkbox"/> | Alcoholism | <input type="checkbox"/> <input type="checkbox"/> | Chicken Pox | <input type="checkbox"/> <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> <input type="checkbox"/> | Rheumatoid Arthritis |
| <input type="checkbox"/> <input type="checkbox"/> | Allergy Shots | <input type="checkbox"/> <input type="checkbox"/> | Diabetes | <input type="checkbox"/> <input type="checkbox"/> | Measles | <input type="checkbox"/> <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> <input type="checkbox"/> | Anemia | <input type="checkbox"/> <input type="checkbox"/> | Emphysema | <input type="checkbox"/> <input type="checkbox"/> | Migraines | <input type="checkbox"/> <input type="checkbox"/> | Scarlet Fever |
| <input type="checkbox"/> <input type="checkbox"/> | Anorexia | <input type="checkbox"/> <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> <input type="checkbox"/> | Mononucleosis | <input type="checkbox"/> <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> <input type="checkbox"/> | Appendicitis | <input type="checkbox"/> <input type="checkbox"/> | Fractures | <input type="checkbox"/> <input type="checkbox"/> | Multiple Sclerosis | <input type="checkbox"/> <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> <input type="checkbox"/> | Arthritis | <input type="checkbox"/> <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> <input type="checkbox"/> | Mumps | <input type="checkbox"/> <input type="checkbox"/> | Tonsillitis |
| <input type="checkbox"/> <input type="checkbox"/> | Asthma | <input type="checkbox"/> <input type="checkbox"/> | Goiter | <input type="checkbox"/> <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> | Bleeding Disorders | <input type="checkbox"/> <input type="checkbox"/> | Gout | <input type="checkbox"/> <input type="checkbox"/> | Pacemaker | <input type="checkbox"/> <input type="checkbox"/> | Tumors, Growths |
| <input type="checkbox"/> <input type="checkbox"/> | Breast Lumps | <input type="checkbox"/> <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> <input type="checkbox"/> | Parkinson's Disease | <input type="checkbox"/> <input type="checkbox"/> | Typhoid Fever |
| <input type="checkbox"/> <input type="checkbox"/> | Bronchitis | <input type="checkbox"/> <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> <input type="checkbox"/> | Pinched Nerve | <input type="checkbox"/> <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> <input type="checkbox"/> | Bulimia | <input type="checkbox"/> <input type="checkbox"/> | Hernia | <input type="checkbox"/> <input type="checkbox"/> | Pneumonia | <input type="checkbox"/> <input type="checkbox"/> | Whooping Cough |
| <input type="checkbox"/> <input type="checkbox"/> | Cancer | <input type="checkbox"/> <input type="checkbox"/> | Herniated Disc | <input type="checkbox"/> <input type="checkbox"/> | Polio | <input type="checkbox"/> <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Cataracts | <input type="checkbox"/> <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> <input type="checkbox"/> | Prostrate Problems | | |

Are you pregnant? Yes No Due Date _____ Current Weight _____ Height _____

List any allergies you have _____

List any injuries/surgeries you have had _____

List any medications/vitamins you take _____

Exercise None Moderate Daily Heavy Work Activity Heavy Moderate Light Sedentary

Smoking Yes No _____ Packs/Day for _____ Years Alcohol Yes No _____ Drinks/Week

I certify that all of the above information is complete and accurate to the best of my knowledge. I agree to notify this facility immediately whenever I have changes in my health condition or health plan coverage in the future.

Signature of Patient, Parent, Guardian, or Personal Representative

Relationship to Patient

Please print name of Patient, Parent, Guardian, or Personal Representative

Relationship to Patient