Welcome

A.L.P Chiropractic & Orthotic Center
5531 Marquesas Circle
Sarasota, Florida 34233
941-927-2715
Fax: 941-927-2615
Email: alpchiropractic@gmail.com

REGISTRATION FORM

Section I: Patient Information Date_____

Name: _____ Occupation: _____

Address: _____City:_____State:_____Zip_____

Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____)_____

Date of Birth: _____ Height:_____ Weight:_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Significant Other ☐ Divorced

Spouse or Parent's Name:_____ Employer_____ Work Phone_____
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____

Email Address_____

Section II: Insurance Information

Please have insurance cards available at time of visit

Name of Insured_____D.O.B_____
Relationship to Patient _____
SSN#:_____ Occupation: _____
Insurance Company_____ Group #_____
ID#_____
Do you have any additional Insurance? ☐ Yes ☐ No (If yes, complete the following information)

Name of Insured_____DOB_____ Relationship to Patient _____
SSN#:_____
Insurance Company_____ Group #_____
ID#_____

Assignment and Release

I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I hereby give permission to the doctor to administer treatment and perform such general procedures, as she may deem necessary in the diagnosis and/or treatment of my condition.

Signature:_____ Date:_____

Welcome

A.L.P Chiropractic & Orthotic Center
5531 Marquesas Circle
Sarasota, Florida 34233
941-927-2715
Fax: 941-927-2615
Email: alpchiropractic@gmail.com

Section III *Patient Condition*

Reason for visit:_____

Have you been to visit a chiropractor before? ☐ Yes ☐ No

Date when your symptoms first appeared?

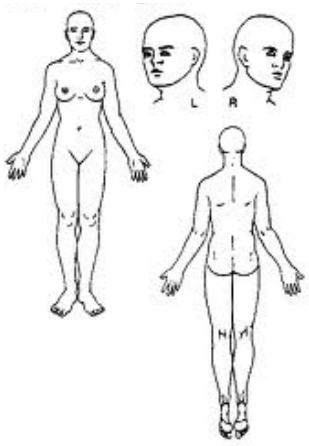
_____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unsure

Mark and X on the picture where you continue to have pain, numbness or tingling. Rate the severity of your pain on a scale from

1 (least pain) to 10 (severe pain).

1----------10



Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Shooting ☐ Burning

☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

How often do you have this pain? _____ Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Daily Routine ☐ Recreation

Welcome

A.L.P Chiropractic & Orthotic Center
5531 Marquesas Circle
Sarasota, Florida 34233
941-927-2715
Fax: 941-927-2615
Email: alpchiropractic@gmail.com

Section IV *Health History*

What treatment have you already received for your condition? ☐ Ice ☐ Heat ☐ Physical Therapy
☐ Surgery ☐ Medication ☐ Other_____

Name and address of other doctors that have treated you for this condition:_____

_____

Date of Last: Physical Exam_____ Spinal E-Ray_____ Blood Test_____

MRI, CT scan, Bone Scan_____ Mammogram/Prostate Exam_____

Please circle all that apply to you:

☐ AIDS/HIV	☐ Chemical Dependency	☐ Measles	☐ Rheumatic Fever
☐ Alcoholism	☐ Chicken Pox	☐ Migraine Headaches	☐ Stroke
☐ Allergy Shots	☐ Diabetes	☐ Miscarriage	☐ Thyroid Problems
☐ Anemia	☐ Emphysema	☐ Mononucleosis	☐ Tonsillitis
☐ Asthma	☐ Epilepsy	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Anorexia	☐ Fractures	☐ Mumps	☐ Tumors, Growths
☐ Appendicitis	☐ Gout	☐ Osteoporosis	☐ Ulcers
☐ Bleeding Disorder	☐ Hepatitis	☐ Phenomena	☐ Venereal Disease
☐ Breast Lump	☐ Herniated Disc	☐ Polio	☐ Other_____
☐ Bronchitis	☐ High Cholesterol	☐ Prostate Problems	_____
☐ Bulimia	☐ Kidney Disease	☐ Psychiatric Care	_____
☐ Cancer	☐ Liver Disease	☐ Rheumatoid Arthritis	_____

If Cancer – What type

_____

Section V *Past Family History*

			Cause of death		*Brother*	*Sister*	*Living*	*Deceased*	*Cause*
Mother	Living	Deceased		**Siblings**:					
Father	Living	Deceased							

Welcome

A.L.P Chiropractic & Orthotic Center
5531 Marquesas Circle
Sarasota, Florida 34233
941-927-2715
Fax: 941-927-2615
Email: alpchiropractic@gmail.com

Section VI *Work Activity/Habits*

Exercise	**Work Activities**	**Habits**	**Information**
☐ None	☐ Sitting > 50%	☐ Smoking	Packs/Day _____
☐ Moderate 3-5 days/wk	☐ standing > 50%	☐ Alcohol	Drinks/wk _____
☐ Heavy > 5 days/wk	☐ Light Labor >50%	☐ Coffee/Caffeine drink	Cups/day _____
☐ Daily	☐ Heavy Labor	☐ High Stress Level	Reason _____

Are you pregnant? ☐ Yes ☐ No Due date:_____

Injuries/Surgeries you have had **Description** **Date**

Falls: _____

Head Injuries: _____

Broken Bones: _____

Surgeries: _____

_____

_____

Medications

Name **What is it taken for?** **How long have you been taking it?**

_____

_____

Name **What are you taking this for?** **How many mg/g/cc are you taking?**

_____

_____

Allergies – Food, Medications, Air Borne

_____

_____