Welcome

Registration Form

PATIENT INFORMATION

Last Name, First Name MI | Title | Preferred Name

Date of Birth | Age | Gender | Marital Status | Spouse/Parent Name

Street Address | City | State | Zip

Mailing Address (if different) | City | State | Zip

SSN | Home Number | Cell Number | Work Number

Email (for private use by this office only) | Employer | Occupation

Whom may we thank for referring us to you? | Other family members seen here

EMERGENCY CONTACT

Name of local friend or relative (not living with you) | Home Phone | Cell Phone

INSURANCE INFORMATION

Person responsible for bill | Is this person a patient here?

Primary subscriber name | Date of birth

Primary Insurance | Phone | ID/SSN # of subscriber | Group #

Secondary subscriber name | Date of birth

Secondary Insurance | Phone | ID/SSN of subscriber | Group #

BACK AND BODY CHIROPRACTIC

CHIROPRACTIC HISTORY

List your problems or complaints, according to severity of pain	Rate your pain, 10 being the worst.	Date started or For how long.
1	1 2 3 4 5 6 7 8 9 10	
2	1 2 3 4 5 6 7 8 9 10	
3	1 2 3 4 5 6 7 8 9 10	

Please answer the following in regards to problem/complain #1 above:

How would you describe the pain? ☐ Sharp ☐ Dull ☐ Diffuse ☐ Achy
☐ Burning ☐ Shooting ☐ Stiff ☐ Numb ☐ Tingly ☐ Sharp with motion
☐ Shooting with motion ☐ Stabbing with motion ☐ Electric like with motion

Is the problem: ☐ getting worse? ☐ staying the same? ☐ getting better?

How often do you experience your symptoms? ☐ Constantly 76-100% ☐ Frequently 15-76% ☐ Occasionally 26-50% ☐ Intermittently 1-25%

How much has the problem interfered with your normal activities? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your work/required tasks? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Do you consider your problem to be severe? ☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem? _____

What makes your problem feel better? _____

What concerns you the most about your problem; what does it prevent you from doing? _____

Who else have you seen for your problem? ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
☐ ER Physician ☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist
☐ No one ☐ Other: _____

What activities do you do at work?

Sit:	☐ Most of the day	☐ Half of the day	☐ A little of the day
Stand:	☐ Most of the day	☐ Half of the day	☐ A little of the day
Computer Work:	☐ Most of the day	☐ Half of the day	☐ A little of the day
On the phone:	☐ Most of the day	☐ Half of the day	☐ A little of the day

What activities do you do outside of work? _____

Anything else we should know? _____

How would you rate your overall health? ☐ Excellent ☐ Very Good ☐ Fair ☐ Poor

What type of exercise do you do? ☐ Strenuous ☐ Moderate ☐ Light ☐ None

Have you seen chiropractor before? _____ If yes, when was your last adjustment? _____

What were the results? ☐ Great ☐ Good ☐ Fair ☐ Poor

HEALTH HISTORY

How many alcoholic drinks do you consume per **week**? _____ How many caffeinated drinks do you consume per **day**? _____
How many times do you eat out per **week**? _____ How many times a **week** do you eat raw nuts or seeds? _____
How many times a **week** do you eat fish? _____ How many times a **week** do you workout? _____
List the **three worst foods** you eat during the **average week**? _____
List the **three healthiest foods** you eat during the **average week**? _____
Do you smoke? _____ If yes, how many times a **day**, _____ a **week**? _____
Rate your stress levels on a scale of 1-10 during the week _____

Please list the 5 **major HEALTH concerns** in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Chronic Sinusitis	☐	☐	Dizziness
☐	☐	Neck Pain	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Upper Back Pain	☐	☐	Chest Pain	☐	☐	Excessive Thirst
☐	☐	Mid Back Pain	☐	☐	Stroke	☐	☐	Frequent Urination
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Smoking/Tobacco Use
☐	☐	Shoulder Pain	☐	☐	Kidney Stone	☐	☐	Allergies
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorder	☐	☐	Depression
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Systemic Lupus
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Epilepsy
☐	☐	Hip Pain	☐	☐	Loss of Bladder Control	☐	☐	Dermatitis/Eczema
☐	☐	Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	HIV/AIDS
☐	☐	Knee Pain	☐	☐	Abnormal Weight Change	☐	☐	Other: _____
☐	☐	Ankle/Foot Pain	☐	☐	Loss of Appetite			_____
☐	☐	Jaw Pain	☐	☐	Abdominal Pain			_____
☐	☐	Joint Pain/Stiffness	☐	☐	Ulcer			_____
☐	☐	Arthritis	☐	☐	Hepatitis			
☐	☐	Rheumatoid Arthritis	☐	☐	Liver/Gall Bladder Disorder	**For Females Only**		
☐	☐	Cancer	☐	☐	General Fatigue	☐	☐	Birth Control Pills
☐	☐	Tumor	☐	☐	Muscular Incoordination	☐	☐	Hormonal Replacement
☐	☐	Asthma	☐	☐	Visual Disturbances	☐	☐	Pregnancy

List all the prescription medications you are currently taking: _____

List all the vitamins/supplements you are currently taking: _____

List all the surgical procedures you have had: _____

METABOLIC ASSESSMENT

Please circle the appropriate number **0 –3** on all questions below.

0 as the least/never to 3 as the most/always

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard dry or small stool	0	1	2	3
Coated tongue of “fuzzy” debris on tongue	0	1	2	3
Pass large amounts of foul smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars or starches	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotions, detergents, etc.	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping or bloating	0	1	2	3
Gas Immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning or aching 1-4 hours after eating	0	1	2	3
Do you frequently use antacids	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0	1	2	3

Category VI

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool digested, foul smelling. Mucous-like greasy or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Lowered gastrointestinal motility, constipation	0	1	2	3
Raised gastrointestinal motility, diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome or Leaky Gut Syndrome?	Yes		No	

Category VIII

Greasy or high fat foods cause distress	0	1	2	3
Lower bowel gas and/ or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History or gallbladder attacks or stones	0	1	2	3
Have you had gallbladder removed	Yes		No	

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Felling shaky, jittery. Tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meal	0	1	2	3
Crave sweets during day	0	1	2	3
Easting sweets does not relieve craving for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII:

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tires, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increased weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrows thins		1	2	3
Thinning of hair on scalp, face, genitals or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII **(MALES only)**

Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XVIII **(MALES only)**

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increased in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX **(Menstruating FEMALES only)**

Perimenopausal	Yes		No	
Alternating menstrual cycle lengths	Yes		No	
Extended menstrual cycle (greater than 32 days)	Yes		No	
Shortened menses (less than 24 days)	Yes		No	
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX **(Menopausal FEMALES only)**

How many years have you been menopausal?	_____		years	
Do you ever have uterine bleeding since menopause?	Yes		No	
Hot Flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

CERTIFICATION

To the best of my knowledge, the previous information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health and/or insurance coverage

Printed Name of PATIENT	Signature of PATIENT or PARENT/GUARDIAN	Date

CONSENT TO TREAT A MINOR

(If applicable)
Back & Body Chiropractic has my permission to render any medically necessary services to my child

Printed Name of PATIENT	Signature of PARENT/GUARDIAN	Date

PATIENT FINANCIAL POLICY

This office had adopted a financial policy that is outlined. If you have any questions regarding this policy, please discuss them with our office manager.

- Unless other arrangements have been made in advance by either you or your insurance carrier, full payment is due at the time of services are rendered.

Your Insurance

- We have made prior arrangements with many insurance carriers to accept assignment of benefits. This means that we will bill those plans for which we have an arrangement and will only require you to pay the authorized co-payment at the time of service. It is the policy of our office to collect this co-payment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have prior arrangement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer may send the payment directly to you. Consequently, the charges for your care and treatment may be due at the time of service.

In the event that your health plan determines a service to be not covered, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, responsibility will fall to the adult accompanying the patient or the parent or guardian with custody for payment.

I hereby authorize Dr. Jonathan Goff to use other diagnostic aids to make a thorough diagnosis of my chiropractic needs. I have answered all questions concerning my medical health history to the best of my knowledge.

- I authorize the release of my medical records to secure payment of insurance benefits.
- I authorize my insurance company to assign benefits to Back and Body Chiropractic for payment of services rendered.
- I authorize the use of this signature on all insurance submissions.
- I have read the copy of the privacy policy information and will/have reviewed the information.

Please note that a cancellation fee will be charged unless notice is given 24 hours prior to a scheduled appointment.

A $25.00 fee will be charged for any returned check plus any recovery fees that may be incurred.

I have read and understand the Financial Policy, Signature Authorization, and Privacy Policy, and I agree to its terms and definitions. I also understand and agree that such terms may be amended from time to time by the practice.

Printed Name of PATIENT	Signature of PATIENT or PARENT/GUARDIAN	Date