

REGISTRATION FORM

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip Code _____ E-mail _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birth date _____ Sex(circle) M F Social Security _____

Emergency Contact _____ Phone _____

Employer _____ Part time _____ Full time _____

Purpose of Appointment _____

Prior Chiropractic Care: Yes _____ No _____ Name _____

Family Physician _____

Serious Illness _____

Current Medications _____

Insured Name _____ Birth date _____

Relationship to Insured _____ Self _____ Spouse _____ Child _____ Other _____

Insured Employer _____

Insured Social Security No. _____

Please mark C=current complaints

P=prior complaints

- | | | |
|------------------------------------------|------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Ringing of ears | <input type="checkbox"/> Constipation/diarrhea |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Cough/hoarseness | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Leg pain | <input type="checkbox"/> Dizziness/lightheaded | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Ankle/foot pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Arm pain | <input type="checkbox"/> Slurred speech | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Wrist/hand pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Menstrual cramps |

Pregnant: No _____ Yes _____ Due date _____

Benningfield and Associates also offers additional services: Please check if you would be interested in any of the following services:

() Acupuncture () Personal training () Physical Therapy () Nutrition () Massage

How did you here about our office? _____