

**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 hear about our office? \_\_\_\_\_