_____ _____

Today's Date E-mail Address

dr. jorge h. garcia
CHIROPRACTOR

2921 N. 23rd St ~ McAllen, TX 78501
(956)687-7878

PATIENT REGISTRATION

Name: _____ Phone: _____ Cell/Other: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Soc. Sec. No: _____ Age: _____ Birth Date: _____ Driver's Lic No: _____

Guardian's Name: _____ Relationship: _____

Primary Insurance: [ ] No [ ] Yes If yes, please provide our office with a copy of insurance card or information.

Name of Employer: _____ Work Phone: _____

Employer's Address: _____

Spouse's Name: _____ Spouse's Phone: _____

Spouse's Employer: _____ Employer's Phone: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Whom may we thank for referring you? _____

Reason for today's visit: [ ] Emergency [ ] New Injury [ ] Old Injury [ ] Chronic Pain [ ] Wellness

Are you in pain? [ ] No [ ] Yes If so, where does it hurt? Right_____ Left_____ Upper_____ Lower_____

Have you had this problem (or similar problem) before? [ ] Yes [ ] No

On a scale of 0-10, where would you rate your discomfort? _____ Is it a sharp pain or like a dull ache? [ ] Sharp [ ] Dull

Does it throb, hurt, or is it more of a steady unchanging pain? [ ] Throb [ ] Hurt [ ] Steady

Does it hurt all the time or does it start and stop? [ ] All the time [ ] Start and stop

If it starts and stops, how many times a day does it happen and how long is it each occurrence?

_____ times per _____ [ ] minutes [ ] hours

Does the pain follow any type of pattern?	[ ] No	[ ] Yes
Does it interfere with your sleep?	[ ] No	[ ] Yes
Does anything make the pain worse?	[ ] No	[ ] Yes
Does anything make it better?	[ ] No	[ ] Yes
Have you taken aspirin or any other medications?	[ ] No	[ ] Yes
Does medication help?	[ ] No	[ ] Yes

Health History

Please indicate with a check mark whether you now or have ever been treated for:

	YES	NO		YES	NO		YES	NO
Heart murmur			Ulcer/Colitis			Emotional Disorder		
Heart surgery/Pacemaker			Shingles			Fainting/Seizures/Epilepsy		
Cancer			Rheumatic Fever			Glaucoma		
Artificial Valves			Chemotherapy			Liver Disease		
Heart Attack/Stroke			Kidney Disease			VD (Syphilis, Gonorrhea)		
Emphysema/Asthma			Sinus Problems			Tuberculosis		
Anemia/Diabetes			Difficulty Breathing			HIV+/AIDS/ARC		
Artificial Bones/Joints/ Implants			Abnormal blood pressure			Alcohol/ Drug Abuse		
Arthritis			Congenital Heart Defect			Mitral Valve Prolapse		
Frequent Neck Pain			Lower Back Problems			Severe/Frequent Headaches		

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Please list any surgeries with dates and/or any other serious medical condition(s) not listed on the first page:_____

_____

List any past serious accidents with dates: _____

Do you take supplements or Vitamins? [ ] No [ ] Yes Do you exercise? [ ] No [ ] Yes _____hours per week

Do you smoke? [ ] No [ ] Yes How much? _____ How long? _____

Are you wearing: [ ] Shoe Lifts [ ] Inner Soles [ ] Arch Supports Are you dieting? [ ] No [ ] Yes Since: _____

General health: [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Name and phone of Physician: _____

Date of last Physical Examination: _____ Any major changes in health during the past year? [ ] Yes [ ] No

Do you have any other medical problems not listed above? [ ] No [ ] Yes _____

Circle if you are allergic to: Penicillin Local Anesthetic Codeine Latex Other_____

List other allergies not mentioned above: _____

Please list any medication you are presently taking: (Name, for what condition?)_____

_____

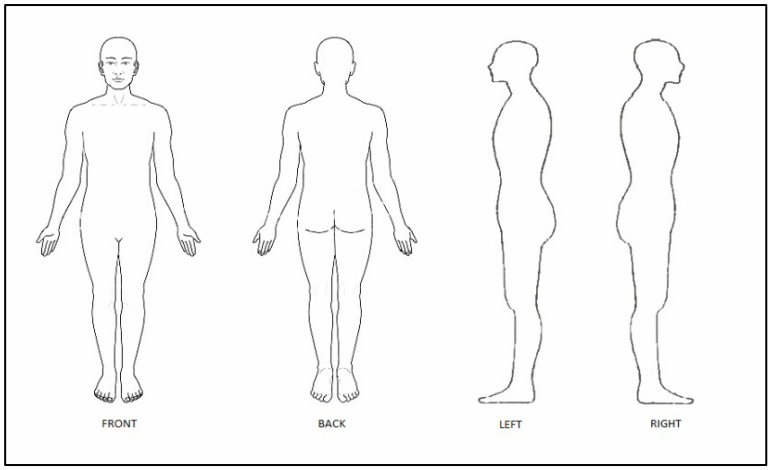
_____

FOR WOMEN: *Are you taking birth control? [ ] No [ ] Yes*

Are you nursing? [ ] No [ ] Yes

Are you pregnant? [ ] No [ ] Yes If so, how many weeks? _____

Use the adjacent body chart and circle all affected areas:



Have you been treated by a Medical Physician for this condition? [ ] No [ ] Yes

If so, where? _____

_____

Have you ever been treated by a Chiropractor?

[ ] No [ ] Yes

If yes, please provide the following information:

Clinic/Dr's name: _____

Clinic phone: _____

ASSIGNMENT OF INSURANCE BENEFITS / CONSENT TO TREATMENT

I have reviewed the health history and believe it to be correct. If there is any change in health or medication take, I will inform the doctor at my next appointment.

I authorize payment of insurance benefits otherwise payable to me directly to the doctor. I also consent to treatment by the health care providers of this medical practice.

I also hereby authorize the release of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.

I have read a copy of the Privacy Notice and was given an opportunity to object to disclosure of my protected health information.

I permit a copy of this authorization to be used in place of the original.

Patient Signature: _____ Date: _____

If under 18-parent/ guardian signature [ ] Adult Patient [ ] Parent/Guardian [ ] Spouse