

**Plainfield Chiropractic Office / Dr. Craig J. Dykgraaf**  
**Registration & History**

Date \_\_\_\_\_ Patient # \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle (initial) {Nickname}

Address \_\_\_\_\_  
Street (Apt) City State Zip

Phone \_\_\_\_\_  
Home Work Cell

SS# \_\_\_\_\_

E-mail \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ Sex M  F

Married  Widowed  Single  Minor

Partnered  Separated  Divorced

Occupation \_\_\_\_\_ How long \_\_\_\_\_

Patient Employer / School \_\_\_\_\_

Employer / School Address \_\_\_\_\_

Employer / School Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Address [if different] \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Spouse's Social Security # \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

How did you find us or hear about us? Phone  Web  Other \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone number(s) \_\_\_\_\_

**INSURANCE**

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Is patient covered by additional insurance? Y  N  [If yes please give the secondary Insurance next]

Insurance Co. \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Further, I understand that the Doctor's office will bill insurance carrier and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. If a report or other documents are needed to help you receive reimbursement there will be a nominal charge. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable. Also, the Doctor's office will not become involved in any disputes with your insurance carrier regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information.

I here by authorized the Doctor to examine and treat my condition as he deems appropriate, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for the x-ray examination only and the x-ray negatives will remain the property of this office. It is further agreed that I am responsible for all charges incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's / Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT CONDITION AND ACCIDENT / INJURY INFORMATION**

1. Is today's problem caused by: Auto accident  Workman's Compensation  Other \_\_\_\_\_

2. Indicate where you have problem / pain / symptoms

**1** primary \_\_\_\_\_  
What hurts, bothers you the most, gives you the most pain

**2** secondary \_\_\_\_\_  
What area would be second in pain stiffness etc.

**3** tertiary \_\_\_\_\_  
What would be the third or next area that is painful, sore, stiff or hurts. Write n/a if none.

Please correlate the above 1,2,3 with the 1,2,3 below.

3. How often do you experience your symptom?

1 2 3 Constantly (76-100% of the time)

1 2 3 Occasionally (26-50% of the time)

1 2 3 Frequently (51-75% of the time)

1 2 3 Intermittently (1-25% of the time)

4. How would you describe the pain?

1 2 3 Sharp

1 2 3 Numb

1 2 3 Dull

1 2 3 Tingly

1 2 3 Diffuse

1 2 3 Sharp with motion

1 2 3 Achy

1 2 3 Shooting with motion

1 2 3 Burning

1 2 3 Stabbing with motion

1 2 3 Shooting

1 2 3 Electric like with motion

1 2 3 Stiff

1 2 3 Other: \_\_\_\_\_

5. How are your symptoms changing with time?

1 2 3 Getting worse    1 2 3 Staying the same    1 2 3 Getting Better

6. Using a scale from -1 (10 being the worst), how would you rate your problem?

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

7. How much has the problem interfered with your work?

1 2 3 Not at all

1 2 3 A little bit

1 2 3 Moderately

1 2 3 Quite a bit

1 2 3 Extremely

8. How much has the problem interfered with you Social activities?

1 2 3 Not at all

1 2 3 A little bit

1 2 3 Moderately

1 2 3 Quite a bit

1 2 3 Extremely

9. Who else have you seen for your problem(s)?

Chiropractor

Primary Care Physician

ER physician

Orthopedist

Orthopedist

Physical Therapist

Massage Therapist

NO one

Other \_\_\_\_\_

1. How long have you had this problem

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

11 How do you think the problem began?

1 \_\_\_\_\_  
 2 \_\_\_\_\_  
 3 \_\_\_\_\_

12. Do you consider this problem to be severe?

1  Yes  Yes, at times  NO  
 2  Yes  Yes, at times  NO  
 3  Yes  Yes, at times  NO

13. What aggravates you problem?

1 \_\_\_\_\_  
 2 \_\_\_\_\_  
 3 \_\_\_\_\_

14 What concerns you the most about your Problem; what does it prevent you from doing?

1 \_\_\_\_\_  
 2 \_\_\_\_\_  
 3 \_\_\_\_\_

15. What is your: Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_  
 Occupation \_\_\_\_\_

16 How would you rate your overall health?

Excellent  Very Good  Good  Fair  Poor

17. What type of exercise do you do?

Strenuous  Moderate  Light  Fair

18. Indicate if you have any immediate family members with any of the following:

Rheumatoid Arthritis  Diabetes  Lupus  
 Heart problems  Cancer  ALS

19. For each of the conditions listed below, place a check in the “past” column if you have had the conditions in the past. If you presently have a condition listed below, place a check in the “present” column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headache	<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Muscular In coordination
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Visual Problems
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Dizziness
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pain	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke CVA TIA	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Lupus
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> Skin problems
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain /Loss	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain / Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<b>Females Only</b>	
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills

- |                          |                          |                      |                          |                          |                             |                          |                          |                      |
|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer                       | <input type="checkbox"/> | <input type="checkbox"/> | Hormonal Replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer               | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis                   | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy            |
| <input type="checkbox"/> | <input type="checkbox"/> | Tumor                | <input type="checkbox"/> | <input type="checkbox"/> | Liver Gall Bladder disorder |                          |                          |                      |

2. List all the prescription medications you are currently taking:

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21. List all the over-the-counter medications you are currently taking.

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22. List all the Vitamins and or herbals you are taking

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23. List all the Surgical procedures you have had:-

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24. What activities do you do at work?

- |   |  |                                       |  |                                     |
|---|--|---------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> <b>Sit:</b>      | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> little of the day | <input type="checkbox"/> not at all |
| <input type="checkbox"/> <b>Stand:</b>    | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> little of the day | <input type="checkbox"/> not at all |
| <input type="checkbox"/> <b>Phone:</b>    | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> little of the day | <input type="checkbox"/> not at all |
| <input type="checkbox"/> <b>Computer:</b> | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> little of the day | <input type="checkbox"/> not at all |

25. What activities do you do out side of work?

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26. Have your ever been hospitalized?  No  Yes  
If yes, why?

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27. Have you had significant past trauma?  No  Yes  
If yes, what kind of trauma?

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28. Anything else pertinent to your visit today?

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Have you been Disabled Yes No When \_\_\_\_\_ Retained an attorney Yes No  
Have you had Chiropractic care in the past Yes No When \_\_\_\_\_  
Doctor's Name(s) \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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