Bruce Resnick, **Chiropractic Physician, Complete Chiropractic Care**
4915 E. Baseline Rd. Suite 101, Gilbert, AZ 85234, (480) 926-7100, Fax: (480) 926-7101

Patient Registration and History Questionnaire

Name: ____ Age: _________ Date of birth: _____________ Date: ___________
LAST **FIRST** **MIDDLE**

Address: _____________________________________ Social Security #: _______________________ … Male … Female

City, State, Zip: ________________________________ Marital Status: … M … S … W … D # of Children_________

Home Phone (_____)_____________________________ Work Phone (______) _________________________________

Email: ____

Employer: _____________________________________ Spouse's Name: _______________________________________

Occupation: ___________________________________ Spouse's Employer: ____________________________________

In case of emergency, notify______________________ Relationship: _____________ Phone (_______) ___________

Chief Complaint or Reason for Office Visit: ____

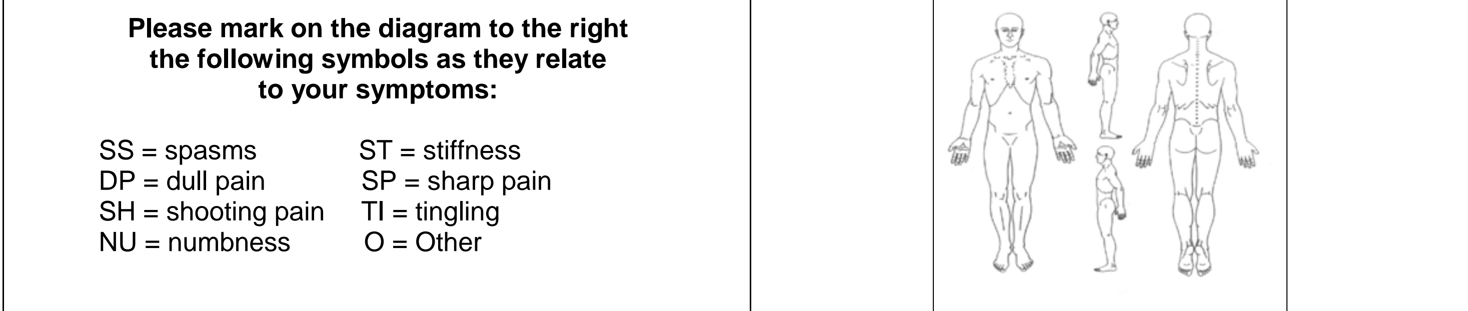
Specific Date and Time of Onset of Symptoms: ____

What makes your symptoms **better**? ____________________ What makes your symptoms **worse**? _________________

What is the quality of your symptoms? (**ache, burn, dull, sharp, throbbing**): ___________________________________

Are your symptoms local or do they travel to another area? (If they travel, to where?) _____________________________

Are symptoms; …Constant >76% …Frequent 51-75% …Occasional 26-50% …Intermittent <25% **of your waking hours**



Please list all medications and dosage: **Frequency** **For What Illness?**

____

____

List any allergies to medications, foods or other: ____

Are you pregnant? … **Yes** … **No** First day of last menstrual cycle: ______________________________________

Do you smoke? … Yes … No; How much? ___________ Do you drink alcohol? … Yes … No; How much? ___________

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Patient's Name: ____ Date: ____________________

Please list all serious illness and serious accidents:	**Month and Year**	**City, State**

Please list any recent x-rays, lab or other tests:	**Date**	**Facility/Doctor**

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis … Yes	Lung Disease … Yes	Gout … Yes	Diabetes … Yes
Kidney Disease … Yes	Stomach/Ulcer … Yes	Heart Disease … Yes	Hepatitis … Yes
Sciatica … Yes	Blood Pressure … Yes	Transfusion … Yes	Polio / MS … Yes
Colon Disease … Yes	Stroke … Yes	Cancer … Yes	Bleeding … Yes
Paralysis … Yes	Seizures … Yes	Arthritis … Yes	Asthma … Yes
Anemia … Yes	Thyroid Disease … Yes	Drug Dependence … Yes	AIDS … Yes

Any other condition(s) not listed above that the doctor should be made aware of:

____

YOUR GROUP HEALTH INSURANCE COMPANY: ____

Address: ______________________________Telephone: (____ _) ______________Insured: _______________

Date of Birth: _________________________Policy #: _______________________ SS#: ________________

Telephone: (______) _______________________ Fax: (_______) ________________________

HIPAA Compliance

Bruce Resnick, DC is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: ______________________________ Date:_________________________________

Witness: ______________________________________Date: _________________________________

Staff Initials: _______________