Bourque Chiropractic Clinic

17487 Old Jefferson Hwy Ste D Prairieville, LA 70769 225-744-3902

REGISTRATION

Date: ____________________ Phone: ________________________

Patient: ____
Last Name First Name Initial

Street Address: ____

City/State/Zip Code: ____

Sex: ☐ M ☐ F Age: ____ Birthdate: ______ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____________________ Email: ____

Insured's Name: ____
Last Name First Name Initial

Present Complaints (Please circle the appropriate ones)

Headache	__/10	Feet/Hands Cold	__/10	Unbalanced	__ Yes __ No
Mental dullness	__/10	Depression	__/10	Fainting	__ Yes __ No
Loss of memory	__/10	Rib pain	__/10	Blurred vision	__ Yes __ No
Dizzy	__/10	Nervousness	__/10	Irritability	__ Yes __ No
Neck Pain	__/10	Eye strain/pain	__/10	Double vision	__ Yes __ No
Upper back pain	__/10	Shortness of breath	__/10	Loss of smell	__ Yes __ No
Lower back pain	__/10	Fear	__ Yes __ No	Chest pain	__/10
Midback pain	__/10	Confusion	__ Yes __ No	Ears ringing/buzzing	__Yes __No
Pins and needles in hands right/left	__/10	Pins and needles in arms right/left	__/10	Pins and needles in legs right/left	__ Yes __ No

Medical Implants: ____________________ **Medical alerts:** __________________

Surgical Implants: ____________________ **Pregnancy:** **yes** ____ **no** ____

PAIN SCALE: Rate the severity of your pain by filling in the pain scales above.

Patient Name: ____ Date: ________________

Doctor's Initials ________________

Medications: *(please list all medications and supplements that you currently take)*

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

Allergies: *(please list all medications that cause allergic reaction)*

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

Smoking: ___ Yes ___ No If yes, _______ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week ________

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery ______________________________________ Date ____________________

______________________________________ ____________________

______________________________________ ____________________

______________________________________ ____________________

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

□ asthma □ pulmonary embolism □ respiratory arrest
□ COPD □ pneumonia □ sleep apnea
□ emphysema □ tuberculosis □ other: ______________________

Cardiac / Heart and peripheral vascular disease

□ chest pain / angina □ high blood pressure □ irregular heartbeat, arrhythmia
□ heart attack □ heart murmur, valve disorder □ peripheral vascular disease
□ congestive heart failure □ mitral valve prolapse □ deep vein thrombosis
□ other: ______________________ □ bleeding problems

Neurologic Disorders

□ stroke or TIA □ Parkinson's □ cerebral palsy
□ peripheral neuropathy □ MS □ polio
□ other: ______________________

Bone & Joint Disorders

□ osteoarthritis □ gout □ osteomyelitis
□ rheumatoid arthritis □ lupus □ ankylosing spondylitis
□ other: ______________________

Patient Name: ____ Date: ________________

Bourque Chiropractic Clinic

Doctor's Initials __________________

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer □ diverticulitis □ hepatitis - Type ______
□ acid reflux, GERD □ irritable bowel □ liver disease
□ GI bleed □ inflammatory bowel disease
□ other: ____________________

Genitourinary Disorders

□ urinary tract infection □ kidney problems □ dialysis, kidney failure
□ bladder problems □ kidney stones □ other: ____________________

Metabolic & Other Disorders

□ Diabetes x ________ years □ skin disorder _____________ □ depression
□ thyroid problems □ psoriasis □ anxiety
□ sickle cell disease □ any skin ulcer □ alcohol or drug dependency
□ high cholesterol or lipids □ tooth abscess, gingivitis □ other: _________________

Cancer: any type -- please specify
____

Other medical problems NOT included above (explain)
____
____

Family History:

Please indicate with an "X" any significant family medical history or problems.

□ asthma □ tuberculosis □ sleep apnea
□ COPD or Emphysema □ other lung: ________________________
□ heart attack, myocardial infarction □ congestive heart failure
□ irregular heartbeat, arrhythmia □ bleeding problems □ Peripheral neuropathy
□ MS or Parkinson's □ other neuro: __________________
□ osteoarthritis □ Lupus □ gout
□ rheumatoid arthritis □ Other bone & joint: ____________________
□ acid reflux, GERD □ inflammatory bowel disease □ hepatitis - Type _____
□ liver disease □ other GI: ______________________
□ kidney problems □ dialysis, kidney failure
□ diabetes □ psoriasis □ high cholesterol or lipids
□ thyroid problems □ sickle cell disease □ any skin ulcer
□ Malignant hyperthermia

Cancer: any type -- please specify
____

Other medical problems NOT included above (explain)
____
____

Patient Name: ____ Date: _______________

Bourque Chiropractic Clinic

Doctor's Initials _______________

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

☐ Medicare	☐ Aetna	☐ Auto Accident
☐ Medicaid	☐ Major Medical	☐ Union Plan
☐ Blue Cross/Blue Shield	☐ Worker's Compensation	☐ Other

Insurance Identification Number: ____

Medicare/Medicaid Identification Number: ____

Major Medical or Auto Insurance:

Date of Accident: _______________

Insurance Company Name: ____

Adjuster: ____

Address/Phone: ____

Claim #: __________________ Policy #: ____________________ Effective Date: ____________

Primary Care Physician:

Name & Address:

____

____

Phone #: ____

LEGAL INFORMATION:

Attorney Name & Address:

____

____

Attorney Phone #: ____

*Person to contact in an emergency (Name and Phone #):

____

Patient Name: ____ Date: ____________

Bourque Chiropractic Clinic

Doctor's Initials ________________