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

REGISTRATION

Date: _____ Phone: _____

Patient: _____
Last Name First Name Middle Initial

Street Address: _____

City/State/Zip Code: _____

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

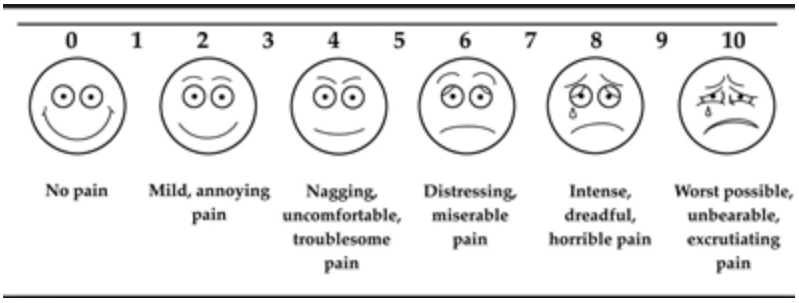
Occupation: _____ Social Security #: _____

Email: _____

Insured's Name: _____
Last Name First Name Initial

Present Complaints (Please fill in a pain scale for any **<u>current complaints</u>**.)

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



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 alerts: _____ Date current complaints started: _____

How did this occur? _____

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 _____

Pregnancy: yes ____ no ____

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

Surgery _____ Date _____
_____ _____
_____ _____

Surgical Implants: _____ **Medical Implants: _____**

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: _____

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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)

_____

_____

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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: _____

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