Advanced Chiropractic & Rehab Corporate Dr. Suite 385
Shelton, CT 06484 (203) 929-5500
Patient Registration

Today's Date:	PCP:

PATIENT INFORMATION

last name: First:	M	Marital status: Married__ Divorce___ Single____ Civil Union__ Other ___

Mailing Address:	Town: ST: Zip:	Birth date:	Age:	Sex: M F

Email

Social Security no.:	Home phone no.:	Cell phone no.: Cell Phone Carrier:
Occupation:	Employer:	Employer phone no.:
Have you seen a Chiropractor _____	When:	For what:

Is your visit here due to an Accident Yes ____ No ____

Motor Vehicle _____ Workers Comp _____ Personal Injury _____ Date of Injury_____

Do you have a Lawyer _____ Name, Address & Phone number _____

_____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Insurance Company

Primary:

Secondary:

IN CASE OF EMERGENCY

Name of friend/relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

Notice of privacy Practice:_____ Date _____

Health Information

Name: _____

Is this due to an Accident: ___Workers Comp ___Personal Injury ___Motor Vehicle?

Were you injured ___No ___Yes Please Explain_____

What is your major Complaint: _____?

How did this problem Begin (fall, Lifting, MVA, Work, Etc.)_____

How long have you had this condition: _____Have you had this similar conditions in the past_____

What activities aggravates your condition _____

What relieves your condition_____? How long has it been since you felt

Good_____ Have you been treated by another Chiropractor ____No/____Yes if yes name of

Chiropractor _____ Phone #_____Last seen_____

Cervical Spine (Neck)

__Neck Pain __Headaches __Thyroid Conditions __Sinusitis __Allergies __Depression __Cold Hands

__Pain into your shoulder/arms/hands __Numbness/tingling in arms/hands __Weakness in grip

__Ears ringing/loss of hearing __Visual disturbances __High blood pressure __Sleeping problems

__Recurrent cold/flu __Low energy/fatigue __TMJ pain/clicking __Loss of balance

Thoracic Spine (Upper and Mid Back)

__Heart palpitations __Diabetes __Tachycardia __Mid back pain __Rib/chest pain __Nausea

__Heart attacks/angina __Asthma/wheezing __Shortness of breath __High Cholesterol

__Recurrent lung infections/bronchitis __Pain on deep inspiration/expiration __Hypoglycemia

__Stomach upset __Ulcer/Gastritis

Lumbar Spine (Low Back

__Pain in your hips/legs/feet __Muscle cramps in your legs/feet __Constipation/diarrhea __Coldness in your legs/feet

__Weakness in your hips/knees/ankles __Menstrual irregularities/cramping __Numbness/tingling in your legs/feet

__Frequent/difficulty urinating __Low back pain __Sexual dysfunction

Drugs you are now taking

__Nerve pill ___Muscle Relaxers ___Pain Killers ___Insulin ___Tranquilizers

___Birth Control ___Pop Pills ___Other_____

Vitamin Supplements you now Take_____

Sleeping Position __Side ___Back ___Stomach do you wear ___Heals ___Arch Support?

Is there a family history of ___Heart Disease ___Cancer ___Stroke?

Do you have children ___No ___Yes (ages) _____

Date of last Physical examination _____ Do you Exercise ___No ___Yes

Please list any health conditions not mentioned: _____

Are you pregnant __No __Yes how many weeks_____ Due Date: _____?

List surgical operations_____

Lifestyle

Do you Exercise? __No __Yes How often _1x _2x _3x _4x _5x _6x _7x per week Other_____

What activities do you do Running, Walking, Weights, Cycling, Yoga, Swimming, Other _____?

Do you smoke __No __Yes how many packs per day _____Any desire to quit __Yes __NO?

Do you drink alcohol __No __Yes what and how much_____

Do you drink Coffee __No __Yes how many cups per day _____

Do you drink Soda __No ___Yes how many cups per day? _____

Do you drink water __No ___Yes how much per day? ____

Do you eat vegetables and fruits __No __Yes How many servings a day _____

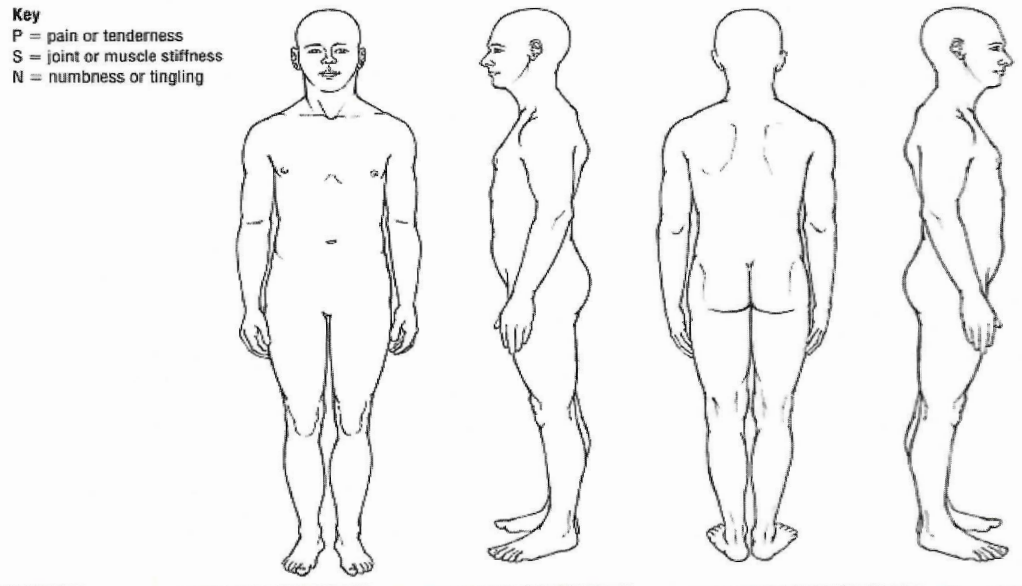
How often do you eat processed foods __Never __Rarely __Occasionally __Often __Exclusively?

What is your average stress level (including work, school, family?)__ Very Low __Low __Moderate __High Very __High

How many hours of sleep do you sleep each night _____

On a scale of 1-10, please rate your pain level

Low __1 __2 __3 Moderate Pain __4 __5 __6 Intense Pain __7 __8 __9 Emergency __10



Advanced Chiropractic & Rehab

4 Corporate Dr. Suite 285

Shelton, CT 06484

203-929-5500

Policies & Procedures

Hours of operation:

Mondays-Wednesdays –Fridays (Chiropractic & Massage) 9:00a.m – 1:00 pm,

(Chiropractic) 3:00pm – 6:00pm, **(Massage)** 2:00pm – 6:00pm

Tuesdays (Chiropractic) 2:00pm -6:00pm **(Massage)** 1:00pm -6:00pm

Thursdays (Chiropractic) 11:00am – 6:00pm **(Massage)** 10:00am – 6:00pm

Massage times

Please arrive on time for all massage appointments so your therapist can discuss your needs and start your session on time.

1 Hour session is 53 minutes hands on and ½ hour session is 23 minutes hands on

Last schedule apt is 12:45; 5:45 these times need to be scheduled. If you come in beyond these times, you may not be seen.

Office is closed from **1:00 -3:00** for **Chiropractic** & **1:00-2:00** for Massage on M-W-F

We will not be able to accommodate patients during lunch hours.

Cancellation Policy – there is a **$50.00** fee for all apt canceled less than **24 hours**.

If you have a massage scheduled and you are more than **10min** late, your appointment will be rescheduled.

If you are scheduled for Chiropractic and you are late you will be seen after scheduled patients.

All patients that have a scheduled apt will be seen first

Same day call in's will be seen second, and all walk in last.

Print Name:_____

Patient Signature: _____

Date: _____

Dr. Lawrence Wilner D.C

4Corporate Dr. Suite 285

Shelton, CT 06484

203-929-5500

Fax# 203-926-1220

I, _____ give my permission for Dr. Lawrence Wilner D.C to

Text / E-mail me for the purpose of appointment reminders and special events.

Cell Phone # _____ Cell Phone Provider _____

E-Mail Address_____

Signature _____

Date _____