

Stork Spinal Care Registration Form  
 2011 N Locust Grove Rd, Meridian, ID 83646 phone (208) 888-8797 fax (208) 888-8799

|  |  |  |   |
|--|--|--|---|
| Last Name:                               | First Name:                              | Middle:                                  | Gender:   |
| <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input type="radio"/> M <input type="radio"/> F |
| Address:                                 |  | Home Phone:                              |   |
| <input style="width: 95%;" type="text"/> |  | <input style="width: 95%;" type="text"/> |   |
| City:                                    | State:                                   | Zip:                                     | Cell Phone:                                     |
| <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/>        |
| Occupation:                              | Employer Name & Address                  |  | Work Phone:                                     |
| <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |  | <input style="width: 95%;" type="text"/>        |
| Email Address:                           |  | Parents' Names/Phone (For Minors):       |   |
| <input style="width: 95%;" type="text"/> |  | <input style="width: 95%;" type="text"/> |   |

|   |  |  |
|---|--|--|
| Marital Status:   | Social Security Number:                  | Birthdate:                               |
| <input type="radio"/> S <input type="radio"/> M <input type="radio"/> D <input type="radio"/> W <input type="radio"/> Other | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |

Referred to the office by:

|  |  |  |
|--|--|--|
| Patient Name:                            | Doctor Name:                             | Other:                                   |
| <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |

**Insurance Information (Please give your card to the receptionist.)**

|  |  |  |
|--|--|--|
| Subscriber's Name:                       | Address: (If different)                  | Birthdate:                               |
| <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |
| Occupation:                              | Employer Name & Address:                 | Work Phone Number:                       |
| <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |
| Subscriber's Social Security Number:     | Name of Secondary Insurance:             | Subscriber's Name:                       |
| <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |

**In Case of Emergency**

|   |  |  |
|---|--|--|
| Name of Local Friend or Relative / Relationship to Patient: | Home Phone:                              | Work Phone:                              |
| <input style="width: 95%;" type="text"/>                    | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |

The above information is true to the best of my knowledge. I authorize Stork Spinal Care to release any information required to process my account, collect payment or submit claims to my insurance company. I also authorize my insurance company to release any information to Stork Spinal Care required to process my account, submit payment or process claims on my behalf.

|           |      |
|-----------|------|
| Signature | Date |
|           |      |

In our office, we focus on your ability to be healthy. Our goals are, first to address the issues that brought you to Stork Spinal Care, and second to offer you the opportunity of improved health and wellness in the future. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health. Most times the effects are gradual. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

1. Describe Your Current Symptoms:

|                               |                              |
|-------------------------------|------------------------------|
| When Did Your Symptoms Start? | How Did Your Symptoms Start? |
|                               |                              |

Is This Due To An Accident or Injury?    Yes    No      Date:

Type of Accident:    Auto    Work    Home    Other     

2. How Often Do You Experience Your Symptoms?

Constantly (76 - 100% of the day)

Frequently (51 - 75% of the day)

Occasionally (26 - 50% of the day)

Intermittently (0 - 25% of the day)

3. What Describes the Nature of Your Symptoms?

Sharp    Dull Ache    Numb    Shooting    Burning    Tingling    Stabbing

4. During the PAST 4 WEEKS:

Indicate the Average Intensity of Your Symptoms (10 Being Worst):

Is This Condition Interfering With Your:

Work    Daily Routine    Sleep    Social Activities    Other

5. In General Would You Say Your Overall Health Right Now Is:

Excellent    Very Good    Good    Fair    Poor

6. Have You Experienced Similar Symptoms In the Past?    Yes    No

7. Has This Problem Been Getting    Worst    Better    Staying the Same

8. What Affects Your Symptoms:    Sitting    Standing    Bending    Lifting    Laying Down

9. Please List Previous Treatments/Therapies You Have Tried and Name of Doctor/Therapist:

|                               |  |
|-------------------------------|--|
| Chiropractic                  |  |
| Medical Physician/Neurologist |  |
| Massage Therapy               |  |
| Physical Therapy              |  |
| Vitamins/Herbs                |  |
| Other                         |  |

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date