Stork Spinal Care Registration Form

2011 N Locust Grove Rd, Meridian, ID 83646 phone (208) 888-8797 fax (208) 888-8799

Submit by Email | Print Form

Last Name:	First Name:	Middle:	Gender: ◯M ◯F
Address:		Home Phone:	
City:	State:	Zip:	Cell Phone:
Occupation:	Employer Name & Address	Work Phone:	
Email Address:		Parents' Names/Phone (For Minors):	
Marital Status: ◯S ◯M ◯D ◯W ◯Other	Social Security Number:	Birthdate:	

Referred to the office by:

Patient Name:	Doctor Name:	Other:

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

Subscriber's Name:	Address: (If different)	Birthdate:
Occupation:	Employer Name & Address:	Work Phone Number:
Subscriber's Social Security Number:	Name of Secondary Insurance:	Subscriber's Name:

In Case of Emergency

Name of Local Friend or Relative / Relationship to Patient:	Home Phone:	Work Phone:

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

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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 Syptoms:

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