Maplewood • White Bear
Chiropractic Center

Chiropractic Registration & History

PATIENT INFORMATION

Date:

Patient Name

Address Apt

City State Zip

Email Address ☐ Male ☐ Female Age

Birthday ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered

Occupation Patient Employer/School

Employer/School Address City State

Employer/School Phone # Zip

Spouse's Name Birthday

Spouse's Employer Whom may we thank for referring you?

PHONE NUMBERS

Home Phone Cell Phone

Best time and place to reach you

In case of emergency, contact:

Name Relationship

Home Phone Cell Phone Work Phone

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date:

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Worker Comp ☐ Other

Attorney Name (if applicable) Attorney Phone Number

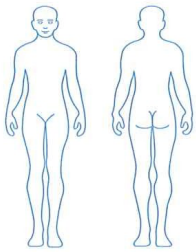
PATIENT CONDITION

Reason for your visit?

When did your symptoms appear?

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain on a scale from 1(least pain) to 10 (most pain)



Type of pain ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Buring ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

If you checked any of the above, please explain:

How often do you have this pain? Is it constant or does it come and go?

Does the pain interfere with any of these? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatments have you received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services

☐ None ☐ Other

Name and address of other doctors who have treated you for your condition

Date of last: Physical Exam Spinal Exam Spinal X-Ray Blood Test

Chest X-Ray Urine Test Dental X-Ray MRI, CT Scan, Bone Scan

Please check if you have experienced or are currently experiencing any of the following:

AIDS/HIV	☐ Yes ☐ No	Cataracts	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Chem Depend	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	High Blood Pre	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	High Cholestrl	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Prostate Problm	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Measels	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No
Bleeding Disor	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	Psychiatric care	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Rheumatoid Ar	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Rheumatic Fevr	☐ Yes ☐ No

Bulimia	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Multiple Sclero	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	STD	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Vaginal Infection	☐ Yes	☐ No			
Suicide Attemp	☐ Yes	☐ No	Tumors	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No			
Thyroid Problm	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No	Other					
Tonsillitis	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No						

If yes, please explain

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS

- ☐ Smoking — Packs/day
- ☐ Alcohol — Drinks/week
- ☐ Coffee/Caffeine Drinks — Cups/day
- ☐ High Stress Level — Reason

Injuries / Surgeries you have had:

	Description	Date
Work Injury		
Motor Vehicle Injury		
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS
Name/Dose

ALLERGIES

VITAMINS/HERBS/MINERALS

Family History

	Living	Age or age at death	List Serious Illnesses
Mother	☐ Yes ☐ No		
Father	☐ Yes ☐ No		
Sisters	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
Brothers	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

Has any member of your family (including children and parents) had any of the following illnesses?

Illness	Which Family Member	Illness	Which Family Member
Anemia or blood disease		High Blood Pressure	
Cancer		HIV disease / AIDS	
Diabetes		Mental Illness / Depression	
Glaucoma		Stroke	
Heart Disease		Other	

FEMALES: GYNECOLOGICAL HISTORY

How many times have you been pregnant? Date of last Pap Smear

Have you ever had an abnormal Pap Smear? ☐ Yes ☐ No Diagnosis Follow up

Have you ever had a sexually transmitted disease? ☐ Yes ☐ No Diagnosis

Date of last mammogram Mammogram Results

Have you ever had a breast biopsy? ☐ Yes ☐ No Biopsy Results

Are you pregnant? ☐ Yes ☐ No Due Date

For Staff Use Only

Reviewed by:_____ Date:_____

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