CHIROPRACTIC REGISTRATION AND HISTORY

Please present your insurance card and photo ID to the receptionist

PATIENT INFORMATION

Date: _____

Patient _____
First M Last

Nick Name_____ Age_____ DOB_____

Address_____

_____
City State Zip

Where do you work? _____

What is your Job/Title? _____

SS#_____

Sex: Female____ Male_____ Race_____

Single___ Married____ Widowed___ Separated___ Divorced___

Spouse's Name (or parent if Minor)_____

Spouse's DOB_____ Employer_____

Whom may we thank for referring you_____

Or how did you hear about us: Yellow pages, Internet, etc…

_____

CONTACT INFORMATION

Home _____

Work_____ Ext. _____

Cell _____ Cell Carrier _____

Primary # to Call: Home_____ Work_____ Cell_____

Preferred contact method: Phone_____ Text_____ E-mail____

E-Mail Address_____

IN CASE OF EMERGENCY, CONTACT:

Name_____ Relationship_____

Home_____

Work_____

Cell_____

Name & Number of nearest relative with whom you are not living _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes____ No____ Date_____

Type of Accident: Auto____ Work_____ Home____ Other_____

Have you made a report of your accident? Yes_____ No_____

To whom: Auto Ins.___ Employer__ Worker Comp___ Other__

Patient Condition:

Chief Complaint_____ Secondary Complaint_____

How did this begin? _____When did your symptoms appear? _____

Is your condition: Getting Worse_____ Improving_____ No Change_____

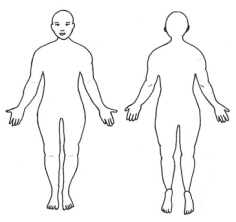
Type of Pain: Achy_____ Sore_____ Dull_____ Sharp _____ Stiff_____ Tight _____
Throbbing_____ Burning_____ Numbness _____ Shooting _____

Is Pain: Mild ____ Moderate ____ Severe ____ Level: 1 (mild) – 10 (severe) _____

Is Pain: Constant_____ Frequent _____ Intermittent _____ Occasional _____

What Aggravates Symptoms? Work _____ Sleep _____ Sitting _____ Standing _____
Walking _____ Bending _____ Lying Down _____ Daily Routine _____

R L L R



Please mark your symptoms

What Alleviates Symptoms? Cold _____ Heat _____ Ibuprofen _____ Tylenol _____ RX _____ Other _____

Have you received chiropractic care in the past? _____ Name of Dr._____

What treatment have you already received for this condition? Chiropractic Services _____ Physical Therapy____
Medication _____ Surgery_____ None _____ Other _____ by Dr. _____

HEALTH HISTORY

WHAT MEDICATIONS ARE YOU TAKING?	WHAT ALLERGIES DO YOU HAVE?	WHAT VITAMINS ARE YOU TAKING?
_____	_____	_____
_____	_____	_____
_____	_____	_____

We can make a copy of a meds. list

Injuries/Surgeries you have had **Description** **Date**

Surgeries _____ _____
Sprain / Strain _____ _____
Head Injuries _____ _____
Broken Bones/Dislocations_____ _____

Hospitalization _____ _____
Date Reason

Major Illness _____ _____
Date Reason

Do you have: (please circle) Pacemaker Defibrillator

Reported Tests
Date of Last: MRI _____ CT-Scan _____ Ultra Sound _____ X-Ray _____

Are you pregnant: No_____ Yes_____ Due Date:_____

HABITS		EXERCISE		WORK ACTIVITY
___Smoking	Packs/Day_____	___None	Frequency	____Sitting
___Alcohol	Drinks/Week_____	___Moderate	1 X Wk.	____Standing
___Coffee	Cups/Day_____	___Heavy	3 X Wk.	____Light Labor
___Pop/Soda	Cups/Day_____		5 X Wk.	____Heavy Labor
___High Stress	Reason_____			

PERSONAL & FAMILY HEALTH HISTORY *It is very important that you complete ALL of this information!

***Place a "X" on "Yes" if it pertains to YOU.**
***Place a "X" on "Fam" if it pertains to a FAMILY member & mark the relationship to you on the Rel. line (ex: mom, grandpa…)**

*AIDS/HIV	___Yes ___Fam – Rel._____	*Fractures	___Yes ___Fam – Rel._____	*Nerve Disorders	___Yes ___Fam – Rel._____
*Alcoholism	___Yes ___Fam – Rel._____	*Glaucoma	___Yes ___Fam – Rel._____		
*Anemia	___Yes ___Fam – Rel._____	*Goiter	___Yes ___Fam – Rel._____	*Osteoporosis	___Yes ___Fam – Rel._____
*Appendicitis	___Yes ___Fam – Rel._____	*Gout	___Yes ___Fam – Rel._____	*Polio	___Yes ___Fam – Rel._____
*Arthritis	___Yes ___Fam – Rel._____	*Heart Attack	___Yes ___Fam – Rel._____	*Prostatitis	___Yes ___Fam – Rel._____
*Asthma	___Yes ___Fam – Rel._____	*Heart Disease	___Yes ___Fam – Rel._____	*Psychiatric Care	___Yes ___Fam – Rel._____
*Bleeding Disorders	___Yes ___Fam – Rel._____	*Hepatitis	___Yes ___Fam – Rel._____		
		*Hernia	___Yes ___Fam – Rel._____	*Rheumatic Fever	___Yes ___Fam – Rel._____
*Breast Lump	___Yes ___Fam – Rel._____	*Herniated Disk	___Yes ___Fam – Rel._____	*Scarlet Fever	___Yes ___Fam – Rel._____
*Cancer	___Yes ___Fam – Rel._____	*High Cholesterol	___Yes ___Fam – Rel._____	*STD	___Yes ___Fam – Rel._____
				*Stroke	___Yes ___Fam – Rel._____
*Chemical Dependency	___Yes ___Fam – Rel._____	*Kidney Disease	___Yes ___Fam – Rel._____	*Thyroid Problems	___Yes ___Fam – Rel._____
*Chicken Pox	___Yes ___Fam – Rel._____	*Liver Disease	___Yes ___Fam – Rel._____		
*COPD	___Yes ___Fam – Rel._____	*Measles	___Yes ___Fam – Rel._____	*Tuberculosis	___Yes ___Fam – Rel._____
* Diabetes	___Yes ___Fam – Rel._____	*Headaches	___Yes ___Fam – Rel._____	*Tumors, Growths	___Yes ___Fam – Rel._____
*Eating Disorders	___Yes ___Fam – Rel._____	*Mumps	___Yes ___Fam – Rel._____	*Ulcers	___Yes ___Fam – Rel._____
*Emphysema	___Yes ___Fam – Rel._____	*Muscular Disorders	___Yes ___Fam – Rel._____	*Other_____	___Yes ___Fam – Rel._____
*Epilepsy	___Yes ___Fam – Rel._____			_____	