Chiropractic Registration and History

Patient Information

Date:_______________________________________

SS/HIC/Patient ID #______________________________

Patient Name:__________________________________
(Last Name)

____
(First Name) (Middle Initial)

Address:_______________________________________

____
(City) (State) (Zip)

E-mail:____

Sex: Male Female Age:_____________

Birthdate:_____________________________________

SSN#:____

Status: (select what applies)

Married Widowed Single Minor

Separate Divorced Partnered for _____Years

Patient Employer/School:________________________

Occupation:____________________________________

Spouse's Name:_________________________________
(Last Name) (First Name)

Birthdate:_____________________________________

Spouse's Employer:______________________________

Phone Numbers

Cell Phone: (___)________________________________

Home Phone: (___)_______________________________

Best time and place to reach you __________________

IN CASE OF EMERGENCY CONTACT

Name:____

Relationship:___________________________________

Home 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 Ins. Employer Workers Comp. Other

Attorney Name:_________________________________

Law Office:_____________________________________

Whom may we thank for referring you?

____

Patient Condition

Reason for Visit:____

When did your Symptoms appear?_______________ Is this condition getting progressively worse?________

What areas do you have pain, numbness, or tingling?____

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

Type of Pain: (check all that apply)

Sharp Dull Numbness Aching Shooting Burning Tingling Cramps Stiffness

Swelling Other

Other:_____________________________How often do you have this pain?___________________

Does your pain interfere with your: (check all that apply)

Work Sleep Daily Routine Recreational Activities

Activities or movements that are painful to perform? : (check all that apply)

Sitting Standing Walking Bending Lying Down

Health History

What treatment have you already received for your condition? (check all that apply)

Medications Surgery Physical Therapy Chiropractic Services None Other:____________

Name and address of other doctor(s) who have treated you for your condition:______________________________

Date Last Seen:

Physical Exam:______________ Spine X-Ray: ______________ Blood Test: ______________

Spinal Exam: ________________ Chest X-Ray: ______________ Urine Test: ______________

Dental X-Ray: _______________ MRI, CT-Scan, Bone Scan:_____________________________

Answer "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV:	Yes	No
Diabetes:	Yes	No
Liver Disease:	Yes	No
Rheumatic Fever:	Yes	No
Alcoholism:	Yes	No
Emphysema:	Yes	No
Measles:	Yes	No
Scarlet Fever:	Yes	No
Allergy Shots:	Yes	No
Epilepsy:	Yes	No
Migraine Headaches:	Yes	No
Anemia:	Yes	No
Fractures:	Yes	No
Miscarriage:	Yes	No
Anorexia:	Yes	No
Glaucoma:	Yes	No
Mononucleosis:	Yes	No
Stroke:	Yes	No
Appendicitis:	Yes	No
Goiter:	Yes	No
Multiple Sclerosis:	Yes	No
Suicide Attempt:	Yes	No
Arthritis:	Yes	No
Gonorrhea:	Yes	No
Mumps:	Yes	No
Thyroid Problems:	Yes	No
Asthma:	Yes	No
Gout:	Yes	No
Osteoporosis:	Yes	No
Tonsillitis:	Yes	No
Bleeding Disorders:	Yes	No

Heart Disease:	Yes	No
Pacemaker:	Yes	No
Tuberculosis:	Yes	No
Breast Lumps:	Yes	No
Hepatitis:	Yes	No
Parkinson's Disease:	Yes	No
Tumors/Growths:	Yes	No
Bronchitis:	Yes	No
Hernia:	Yes	No
Pinched Nerve:	Yes	No
Typhoid Fever:	Yes	No
Bulimia:	Yes	No
Herniated Disk:	Yes	No
Pneumonia:	Yes	No
Ulcers:	Yes	No
Cancer:	Yes	No
Herpes:	Yes	No
Polio:	Yes	No
Vaginal Infections:	Yes	No
Sexually Transmitted Disease:	Yes	No
Cataracts:	Yes	No
High Blood Pressure:	Yes	No
Prostate Problems:	Yes	No
Whooping Cough:	Yes	No
Chemical Dependency:	Yes	No
High Cholesterol:	Yes	No
Psychiatric Care:	Yes	No
Chicken Pox:	Yes	No
Kidney Disease:	Yes	No
Rheumatoid Arthritis:	Yes	No

Other:_________________________

Exercise: None Moderate Daily Heavy

Working Activity: Sitting Standing Light Labor Heavy Labor

Habits: Smoking (Pack per Day):________ Alcohol (Number of Drinks per Day): ________

Coffee/Caffeine Drinks: (Number of Drinks per Day):________ High Stress Level (Reason): ________

Are you Pregnant: Yes No Due Date: ________________

Injuries/Surgeries you have had:

Falls:____

Head Injuries:____

Broken Bones: ____

Dislocations: ____

Surgeries:____

Medications/Allergies/Supplements

Pharmacy Name:____

Pharmacy Phone Number:____