Chiropractic/Acupuncture Registration and History

Personal Information

Date ____________________________ DOB _____________________________

First Name ____ Last Name ____

Middle Initial _________________ Sex _____________________________ SSN ____

Address ____

City ____ State _______________ Zipcode ___________________________________

Cell Phone ____ Home Phone ____

Email ____

Occupation ____ Employer ____

Employer Address ____

Marital Status _______________________________ Spouse's Name ____

Spouse's DOB _____________________________ Spouse's Employer ____

Emergency Contact

Contact Name ____ Relationship _____________________________________

Phone Number ____

Patient Condition

Are you pregnant? ____________________ Due Date ________________________

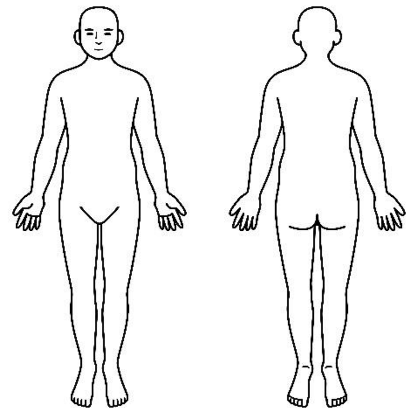
Are you here due to an accident (Auto/Work)? _________________
*If you answered yes, you will need to fill out additional injury paperwork.

Reason for visit ____

When did your symptoms appear? ____

If 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) to 10 (severe pain) ____________

Type of Pain (check all that apply)

- ◯ Sharp/Dull
- ◯ Aching
- ◯ Burning
- ◯ Cramps
- ◯ Swelling
- ◯ Numbness
- ◯ Shooting
- ◯ Tingling
- ◯ Stiffness
- ◯ 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
- ◯ None
- ◯ Other

Name and addresses of other doctor(s) who have treated you for your condition

____

Date of last…

Physical Exam ____________________ Spinal Exam ____________________ MRI ____________________

Spine X-Ray ____________________ Chest X-Ray ____________________ CT-Scan ____________________

Blood Test ____________________ Urine Test ____________________ Bone Scan ____________________

Check All That Apply

- ◯ AIDS/HIV
- ◯ Alcoholism
- ◯ Allergy Shots
- ◯ Anemia
- ◯ Anorexia
- ◯ Appendicitis
- ◯ Arthritis
- ◯ Asthma
- ◯ Bleeding Disorders
- ◯ Breast Lumps
- ◯ Bronchitis
- ◯ Bulimia
- ◯ Cancer
- ◯ Cataracts
- ◯ Chemical Dependency
- ◯ Diabetes
- ◯ Emphysema
- ◯ Epilepsy
- ◯ Fractures
- ◯ Glaucoma
- ◯ Goiter
- ◯ Gonorrhea
- ◯ Gout
- ◯ Heart Disease
- ◯ Hepatitis
- ◯ Hernia
- ◯ Herniated Disc
- ◯ Herpes
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ Kidney Disease
- ◯ Migraine Headaches
- ◯ Mononucleosis
- ◯ Multiple Sclerosis
- ◯ Mumps
- ◯ Osteoporosis
- ◯ Pacemaker
- ◯ Parkinson's Disease
- ◯ Pinched Nerve
- ◯ Pneumonia
- ◯ Prostate Problems
- ◯ Psychiatric Care
- ◯ Rheumatic Fever
- ◯ Rheumatoid Arthritis
- ◯ Sexually Transmitted Disease
- ◯ Stroke
- ◯ Suicide Attempt
- ◯ Thyroid Problems
- ◯ Tonsilitis
- ◯ Tuberculosis
- ◯ Tumors/Growths
- ◯ Ulcers
- ◯ Other:

Exercise Level

- ◯ None
- ◯ Moderate
- ◯ Daily
- ◯ Heavy

Working Activity

- ◯ Sitting
- ◯ Standing
- ◯ Light Labor
- ◯ Heavy Labor

Smoking (Packs/Day) _________________ Alcohol (Drinks/Day) _________________ Caffeine (Drinks/Day _________________

Do you have high stress? _____________ If yes, reason why ____

Injuries/Surgeries

Falls ______________________________________ Head Injuries ______________________________________

Broken Bones ______________________________________ Dislocations ______________________________________

Surgeries ____

Medications/Allergies/Supplements

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