Chiropractic Registration & History

< PATIENT INFORMATION >

Date _____

Patient (Last Name)_____

Name (First Name)_____

Address _____

City _____

State _____ **Zip code** _____

Email _____

Sex ☐ M ☐ F ☐ O

Age _____ **Birthdate**_____

Marital Status

☐ Single ☐ Married ☐ Minor

☐ Other _____

Spouse's Name _____

Spouse's Birthdate _____

< PHONE NUMBERS >

Home Phone _____

Cell Phone _____

Best time to reach you _____

In Case of Emergency, Contact

Name _____

Relationship _____

Cell Phone _____

Work Phone _____

< OTHER INFORMATION >

Occupation/ School _____

Occupation/ School Phone _____

Occupation/ School Address _____

_____

< HOW DID YOU FIND OUT ABOUT OUR OFFICE? >

☐ Ads ☐ Web Searching ☐ Referral - Whom may we thank for referring you? : _____ ☐ Other

< PATIENT CONDITION >

- **Reason for Visit** _____
- **When did your symptoms appear?** _____
- **Is this condition getting progressively worse?**

  ☐ Yes ☐ No ☐ Unknown
- **Mark an "X" on the picture where you continue to have pain and symptoms**
- **Rate the severity of your pain on a scale from 1 (least pain) to 10 (sever pain)** _____
- **Type of Pain**

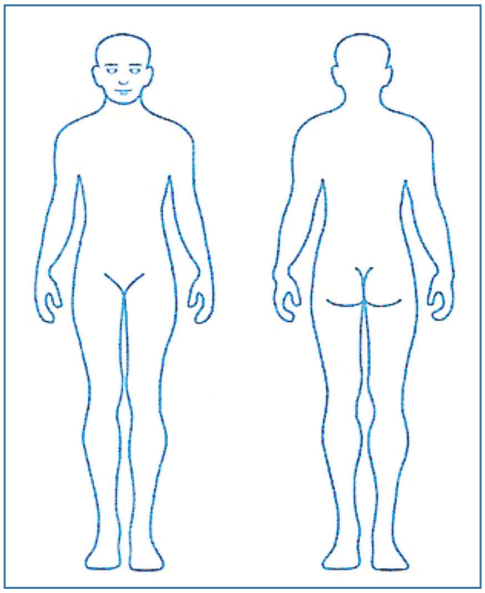
  ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching

  ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramping ☐ Stiffness

  ☐ Swelling ☐ Other _____
- **Is it constant or does it come and go?** _____
- **Does it interfere with your**

  ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other
- **Activities or movements that are painful to perform**

  ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



< HEALTH HISTORY >

- **What treatment have you already received for your condition?**

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Care ☐ Other _____ ☐ None

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

_____

- **Date of Last:**

☐ Physical Exam _____ ☐ Spinal X-ray _____ ☐ Blood Test _____

☐ Spinal Exam _____ ☐ Chest X-ray _____ ☐ Urine Test _____

☐ Dental X-ray _____ ☐ MRI, CT scan, Bone Scan _____ ☐ Other _____

- **Place a mark on "Yes" or "No" to indicate if you have had any of the following:**

AIDS/HIV	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Allergy	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Tumor, Growth	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Fractures	☐ Yes ☐ No	Parkinson's disease	☐ Yes ☐ No	Other _____	
Glaucoma	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	_____	

EXERCISE

☐ None ☐ Moderate ☐ Daily ☐ Heavy

_____days / week

WORK ACTIVITY

☐ Light Labor ☐ Standing

☐ Heavy Labor ☐ Sitting

PREGNANCY

☐ Pregnant ☐ No

* Due Date: _____

HABITS

☐ Smoking : _____Packs / Day

☐ Alcohol : _____Drinks / Week

☐ Coffee/Caffein Drinks : _____Cups / Day

☐ High Stress Level : Reason _____

INJURIES/ SERGERIES

- **Please describe any experiences with falls, head injuries, bone fractures, dislocations, or surgeries.**

- _____ Date _____

- _____ Date_____

MEDICATIONS

_____

_____

_____

(Pharmacy Name/ Phone)

ALLERGIES

_____

_____

_____

VITAMINS/ HERBS/ MINERALS

_____

_____

_____