

Patient History and Registration

Name _____ Age _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Phone (Home) _____ Date of Birth _____ Sex: M F Marital Status: S M D W
 Social Security # _____ Email _____
 Employer _____ Phone (Work) _____ Occupation _____
 Insurance Company _____
 Insured's Name _____ Insured's Date of Birth _____
 Insured's ID. # or S.S. # _____ Type of Insurance __PPO __HMO __POS __MedPay/Auto
 Spouse's Name _____ Spouse's Date of Birth _____ Spouse's Occupation _____
 Present condition due to an __Auto Injury __Work Injury __Other Accident __Unknown Cause
 Who can we thank for referring you? _____ Number of Children _____

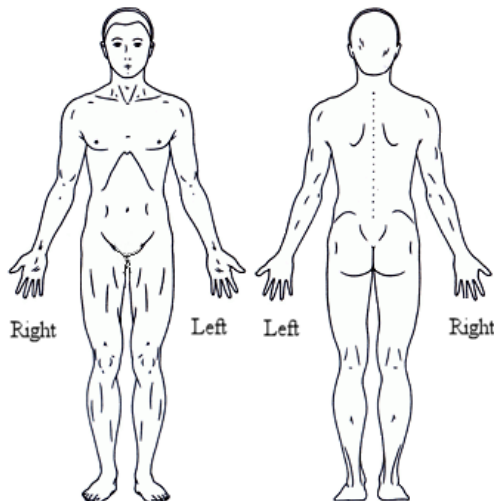
HEALTH REPORT:

What type problem(s) are you experiencing? _____
 Date(s) this or these started? _____ What happened? _____
 Since it began, it is getting? __ Better __ Same __ Worse
 What have you tried that hasn't worked: _____
 This is affecting my __Job __Childcare __Marriage/Sex __Golf __Tennis __Finances __Playing with kids __Bowels
 When its really bad how does it make you feel? _____
 Does it make you feel older?____ Getting rid of problem would increase Quality of Life __10-30% __40-75% __80-100%
 Have you had similar accidents or injuries before? __ Yes __ No If yes, explain: _____
 List the names of any relatives that have or have had a similar problem: _____
 Have you or any relative received chiropractic previously? __ Yes __ No Was it a Positive Experience? _____
 What did you see a chiropractor for and how long: _____
 Have you been treated for any health condition by a physician in the last year? __ Yes __ No
 If yes, explain: _____
 Are you currently taking medication prescription or OTC? __ Yes __ No Do you have any Allergies? _____
 Please list Medications _____
 List the approximate dates of any surgeries: _____
 Previous accidents and date _____ Past Hospitalizations _____
 Who is your family doctor? _____ May we contact them? __Yes __No

Family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's side	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mother's side	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you Smoke Y/N ____ •Alcohol Y/N __Daily __Weekly __Social Occasions •Caffeinated drinks per day ____
 Do you take Vitamins/Supplements Y/N _____ Exercise ? Y/N __Light __Moderate __Strenuous



Please circle degree of pain, 0 none, 10 severe pain.
 No pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain
 Using the symbols below, mark on the pictures where you feel pain.
 Numbness ===
 Dull Ache OOO
 Burning XXX
 Sharp/Stabbing ///
 Pins, Needles +++
 Electric/Shooting ^^^
 Is it ? __Constant __Off & On __Daily __Weekly __Monthly
 What activities aggravate your condition/pain? _____
 What activities lessen your condition/pain? _____
 Is this condition worse during certain times of the day? Y/N
 Is this condition interfering with Work? _____
 Sleep? _____ Routine? _____ Other? _____
 Is this condition progressively getting worse? _____
 Does it radiate down leg or arm? Y/N __Arm __Leg __Both

On a scale of 1 -10 Rate your commitment to getting rid of this problem please circle a number 1 2 3 4 5 6 7 8 9 10
 If we find we can help, is there anything that would prevent you from taking care of this? __Time __Finance __Transportation

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS

- Convulsions
- Dizziness
- Fainting
- Headache
- Nervousness
- Numbness
- Wheezing

MUSCLES & JOINTS

- Low Back Problems
- Pain between Shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Sprains/Strains
- Broken Bones

CARDIO-VASCULAR

- High Blood Pressure
- Heart Attack
- Pain over Heart
- Poor Circulation
- Heart Trouble
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins

EAR/NOSE/THROAT

- Earache
- Ear Noises
- Enlarged Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

GASTRO-INTESTINAL

- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver/Gallbladder
- Nausea
- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting Blood
- Black Stool
- Bloody Stool
- Weight Loss/Gain

RESPIRATORY

- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

GENITO-URINARY

- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Problems
- Loss of Bladder Control

SKIN OR ALLERGIES

- Boils
- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Sensitive Skin
- Allergy _____

FOR WOMEN ONLY

- Birth Control _____
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Periods
- Vaginal Discharge
- Breast Pain

Pregnant at this Time Y/N

People see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause, and others to prevent future ailments. Your doctor will weigh your needs and desires when recommending your health program. Please check the type of care you desire so that we may be guided by your wishes.

Circle one below.

Relief Correction of the cause Prevention Let the Doctor choose for me

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient

Signature _____ Date _____