

CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION	PHONE NUMBERS
Date _____	Home _____
Patient Name _____ Last Name	Business _____
_____	Cell _____
First Name Middle Initial	In case of Emergency, Contact:
Address _____	Name _____
City _____	Relationship _____
State _____ Zip _____	Phone # _____
E-mail _____	EMPLOYMENT INFORMATION
Birthdate _____ Age _____	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> F/T Student <input type="checkbox"/> Retired
Soc. Sec. # _____	Patient Employer/School _____
<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed	Occupation _____
<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Minor (Under 18)	

PATIENT CONDITION

Describe your symptoms _____

When did your symptoms start? _____

How did your symptoms begin? _____

How often do you experience your symptoms?

Constantly (76-100% of the day)

Frequently (51-75% of the day)

Occasionally (26-50% of the day)

Intermittently (0-25% of the day)

Please describe the nature of your symptoms?

Sharp Dull Ache Numb Shooting Burning Tingling Other _____

How are your symptoms changing? Getting better Not changing Worsening

Does the pain spread to other areas? Yes No (if so, where?) _____

During the past 4 weeks:

a) On a scale of 0 to 10, circle the average intensity of your symptoms: 0 1 2 3 4 5 6 7 8 9 10

b) How much has pain interfered with your normal work (including work outside the home and housework)

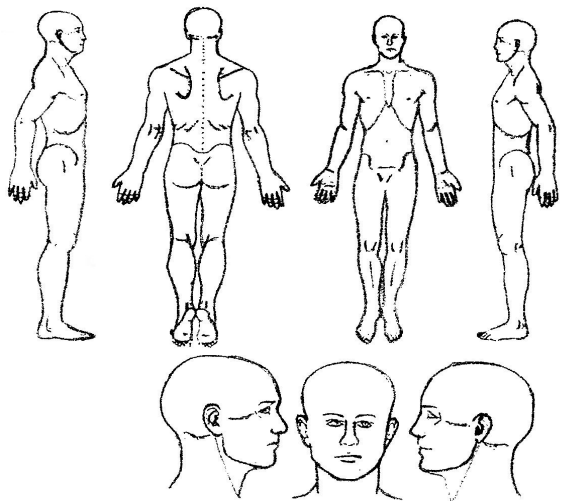
Not at all A little bit Moderately

Quite a bit Extremely

c) How much has your condition interfered with social activities?

All of the time Most of the time Some of the time

A little of the time None of the time



In general, would you say your overall health right now is...

Excellent Very Good Good Fair Poor

HEALTH HISTORY

Who have you seen for your symptoms?

No one Medical Doctor Physical Therapist Chiropractor Other

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

What treatment have you already received and when? _____

Date of Last: Physical Exam _____

For your current symptoms, have you had an MRI CT Scan X-ray Bone Scan Other Diagnostic Testing

Have you had similar symptoms in the past? Yes No

If you have received treatment in the past for the same or similar symptoms, who did you see?

This Office Medical Doctor Physical Therapist Chiropractor Other

REVIEW OF SYSTEMS

Please check any of the following that apply:

- | | | |
|--|---|--|
| <input type="checkbox"/> Headache
<input type="checkbox"/> Migraines
<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Upper Back Pain
<input type="checkbox"/> Mid Back Pain
<input type="checkbox"/> Low Back Pain
<input type="checkbox"/> Shoulder Pain
<input type="checkbox"/> Elbow/Upper Arm Pain
<input type="checkbox"/> Wrist/Hand Pain
<input type="checkbox"/> Hip/Upper Leg Pain
<input type="checkbox"/> Knee/Lower Leg Pain
<input type="checkbox"/> Ankle/Foot Pain
<input type="checkbox"/> Jaw Pain
<input type="checkbox"/> Joint Swelling/Stiffness
<input type="checkbox"/> Spinal Disc Pathology
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anemia
<input type="checkbox"/> Blood Disorder
<input type="checkbox"/> Muscle Aches | <input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Heart Condition
<input type="checkbox"/> Chest Pains (Angina)
<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Vascular Condition/Stroke
<input type="checkbox"/> Lung Condition/Emphysema/COPD
<input type="checkbox"/> Asthma
<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Ulcer
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Liver/Gall Bladder Disorder
<input type="checkbox"/> Heartburn/Indigestion/GERD
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Loss of Bowel Control
<input type="checkbox"/> Colitis
<input type="checkbox"/> Irritable Bowel
<input type="checkbox"/> Cancer/Tumor
<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> Bone Fractures | <input type="checkbox"/> Diabetes
<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Painful Urination
<input type="checkbox"/> Kidney/Bladder Stones
<input type="checkbox"/> Kidney/Bladder Infection
<input type="checkbox"/> Loss of Bladder Control
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Loss of Consciousness
<input type="checkbox"/> Visual Disturbance
<input type="checkbox"/> Earache
<input type="checkbox"/> Ringing in Ears
<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Skin Condition
<input type="checkbox"/> Loss of Appetite
<input type="checkbox"/> Abnormal Weight Gain
<input type="checkbox"/> Depression
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Difficulty Sleeping
<input type="checkbox"/> Allergies |
|--|---|--|

EXERCISE

- None Light
 Moderate Heavy

Consists of: _____

WORK ACTIVITY

- Sit more than 50%
 Stand more than 50%
 Light Labor
 Moderate Labor
 Heavy Labor
 Computer/Telephone

HABITS

- Smoking _____
Packs per day
 Alcohol _____
Drinks per week
 Caffeine _____
Drinks per week

MEN OVER 40

Date of last prostate Exam _____

WOMEN ONLY

- Birth Control Pills
 PMS
 Menopause
 Hormone Replacement
 Pregnancy: Total _____

MEDICATIONS AND DOSAGE	VITAMINS/MINERALS/HERBS	INJURIES/SURGERIES

Please indicate if an immediate family member has had any of the following conditions. Which family member?

- Rheumatoid Arthritis _____
- Diabetes _____
- Heart Condition (Heart Attack, Valve Disease, Blockage) _____
- Stroke _____
- High Cholesterol _____
- Cancer _____
- Other serious health condition not listed: _____

Is there anything else you would like the doctor to know about you, your condition or your general health status? (Please describe) _____

Patient Signature _____ Date _____