REGISTRATION INFORMATION

PATENT INFORMATION

Date_____File#_____

Name_____

Address_____

City_____

State_____Zip_____

SS#_____Sex □ Male □ Female

Date of Birth_____Age_____

Employer_____

Occupation_____

Spouse's Name_____

Spouse's Employer_____

How did you hear of our office?_____

Name of Family Doctor_____

May we contact them regarding your health? □ Yes □ No

Have you ever had chiropractic care? □ Yes □ No

INSURANCE INFORMATION

□Insurance □ Cash/Credit Card □ BWC □ PI □ Other_____

Please provide a copy of your insurance card for verification

Who is responsible for this account?_____

Relationship to patient_____

Insurance Name_____

Group #_____ID#_____

Are you covered by additional insurance? □ Yes □ No

Secondary Insurance Co.:_____

ACCIDENT INFORMATION

Is this injury/condition due to an accident? □ Yes □ No

If yes, date of accident?_____

Type of Accident □ Auto □ Work □ Home □ Other_____

Have you made a report of your accident? □ Yes □ No

To Whom? □ Auto Insurance □ Employer □ Worker's Comp

□ Attorney □ Police □ Other _____

Attorney Name (if applicable)_____

PHONE NUMBERS, E-MAIL & EMERGENCY CONTACT

Home_____Work_____Cell_____Best time to reach_____

E-Mail Address_____ May we contact you by e-mail? □ Yes □ No

Would you be interested in receiving an e-mail health newsletter? □ Yes □ No If yes, please initial:_____

Emergency Contact Information

Name_____Relationship_____Home_____Work_____

CURRENT COMPLAINT/CONDITION(HP)

What is (are) your present complaint(s) and how long has it been bothering you?

1. _____How Long?_____
2. _____How Long?_____
3. _____How Long?_____
4. _____How Long?_____

How did your problem start?_____

Rate your pain level *today:* (please circle one) (*no pain*) 0 1 2 3 4 5 6 7 8 9 10 (*severe pain)*

Is your pain? □ Constant (100% of day) □ Frequent (75% of day) □ Occasional (50% of day) □ Intermittent (25% of day)

Is your condition? □ Getting Better □ Staying the same □ Getting worse

Does it interfere with? □ Work □ Sleep □ Recreation □ Daily Activity □ Nothing □ Other _____

What tests have you had? □ X-rays □ MRI □ EMG □ Ultrasound □ Lab Work If yes, when?_____

What treatment have you had? □ Medical Doctor □ PT □ Medication □ Injections □ Surgery □ Other _____

Has the treatment helped? □ Yes □ No If yes, explain_____

Have you ever had this problem before? □ Yes □ No If yes, explain_____

Have you had chiropractic care for this condition? □ Yes □ No If yes, explain

PATIENT NAME: FILE#

SOCIAL HISTORY

Marital Status/Children	Use of Alcohol	Use of Tobacco	Work Activity	Exercise Activity
□ Single	□ Never	□ Never	□ Sitting	□ None
□ Married	□ Rarely	□ Previously, but quit	□ Standing	□ Light
□ Divorced/Separated	□ Moderate	□ Currently	□ Light Labor	□ Moderate
□ Widowed	□ Daily	_____Packs per day	□ Heavy Labor	□ Strenuous
□ # of Children _____				

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS please check any that apply to you

Constitutional
□ Bad general health
□ Recent weight change
□ Fever
□ Fatigue
□ Headaches

Eyes
□ Eye disease/ injury
□ Glasses or contact lens
□ Blurred/double vision

Ear, Nose, Throat
□ Hard of hearing
□ Ringing in ears
□ Vertigo
□ Sinus problems
□ Nose bleeds
□ Sore throat/voice change
□ Swollen glands

Neurological
□ Seizures or Epilepsy
□ Numbness/Tingling
□ Tremors
□ Stroke

Musculoskeletal
□ Joint Pain/Stiffness
□ Joint Swelling
□ Arthritis
□ Osteoporosis
□ Chronic fatigue
□ Fibromyalgia

Cardiovascular
□ Chest pain/Palpitations
□ Dizziness/Fainting
□ Shortness of breath
□ Swelling in hands/feet
□ High blood pressure
□ High cholesterol
□ Heart attack
□ Congestive heart failure

Gastrointestinal
□ Heartburn
□ Nausea/Vomiting
□ Diarrhea/Constipation
□ Blood in stools
□ Gall bladder problems
□ Liver problems
□ Ulcers

Genito-urinary
□ Pain/Difficulty urinating
□ Blood in urine
□ Incontinence
□ Kidney stones
□ Kidney problems

Respiratory
□ Cough
□ Congestion
□ Wheezing
□ Asthma
□ Emphysema
□ Pneumonia

Psychiatric
□ Anxiety/Depression
□ Mood Swings
□ Difficulty sleeping
□ Memory loss

Hematologic/Lympatic
□ Slow to heal after cuts
□ Bleed or bruise easily
□ Anemia
□ Enlarged glands

Endocrine
□ Excessive thirst/urination
□ Heat or cold intolerance
□ Skin becoming drier
□ Diabetes
□ Thyroid disorder

Integumentary (skin, breast)
□ Rash/Sores
□ Lesions
□ Breast pain or lump
□ Dermatitis/Eczema

Allergic/Immunologic
□ Food allergies
□ Airborne allergies
□ Systemic Lupus
□ Cancer
□ HIV/AIDS

Females only:
Are you pregnant? □ Yes□ No
Use of birth control?□ Yes □ No
Date of last period: ___/___/___

FAMILY HISTORY

	Living		Rheumatoid Arthritis		Cancer		Diabetes		Heart, Lung or Hypertension		Neck, Back, or Disc Problems	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Father	□	□	□	□	□	□	□	□	□	□	□	□
Mother	□	□	□	□	□	□	□	□	□	□	□	□
Brothers/Sisters	□	□	□	□	□	□	□	□	□	□	□	□

LIST ALL PREVIOUS INJURIES, HOSPITALIZATIONS, AND/OR SURGERIES

Injuries/Falls_____
Fractures _____
Hospitalization/Surgeries_____
Other _____

MEDICATIONS	SUPPLEMENTS	ALLERGIES
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

To the best of my knowledge, the questions on these forms have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform this office of any changes in my medical status.

Signature of Patient/Parent_____Date _____Reviewed by_____