

PATIENT REGISTRATION

Patient Information

(Please Print) _____ Date _____

Patient Name _____

Email _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____

SS# _____ DOB _____ Age _____

Married Single Divorced Widowed

Male / Female _____ Your Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Spouse's DOB _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Have you received chiropractic care before? _____

Goals for Care

People see Chiropractors for a variety of different reasons. Some go for relief of pain, some to correct the cause, and others for prevention. Your doctor will weigh your needs and desires when recommending your health program. Please check the type of care desired so we may be guided by your wishes whenever possible.

- Relief Care - Symptomatic relief of pain /discomfort
- Corrective Care - Correcting, relieving, stabilizing
- Prevention - Maintaining the body to the highest
- I want the doctor to select the type of care appropriate for my condition.

List any other Doctors you have consulted for this condition:

Primary Physician _____

Primary Physician Phone # _____

Insurance Information

Who is responsible for this account? _____

Relationship to patient _____

Primary Insurance Company _____

Policy # _____ Group # _____

Secondary Insurance Company _____

Policy # _____ Group # _____

Subscriber's Name _____

Birth Date _____ SS# _____

Accident Information

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home

To whom have you made a report of your accident?

Auto insurance Employer Worker Comp.

Attorney Name (if applicable) _____

Patient Condition

What is your primary reason for seeking care today?

Have you missed any work due to this condition? Yes / No

What treatment have you received for this condition?

- Physical Therapy Chiropractic Services Surgery
- Medication None Other

Name and Phone # of Dr. treating you for this condition.

Date of last:
Physical exam _____

Spinal X-Ray _____

Blood Test _____

Urine Test _____

MRI,CT Scan _____

PATIENT REGISTRATION

List all prescription and non – prescription drugs you are currently using : _____

List any surgeries you have had : _____

List any past broken or fractured bones: _____

Have you ever suffered from:

- | | | |
|---|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Arteriolosclerosis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headache | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |

Do you exercise? No Yes

What type and frequency of exercise?

What activities does your job entail?

- | | | |
|---------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Computer use | <input type="checkbox"/> Repetitive motions | <input type="checkbox"/> Twisting |

How do you rate your diet? (1being excellent and 10 poor)

Do you take vitamins? No Yes

Would you say your sleep is : Good Fair Bad

Your sleeping position is: Back Side Stomach

Do you Smoke? No / Yes How Much? _____

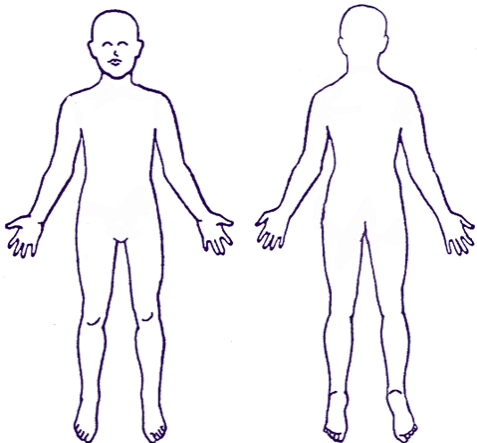
How would you rate your stress levels? (1 = excellent 10 = poor)

Home: **1 2 3 4 5 6 7 8 9 10**

Work: **1 2 3 4 5 6 7 8 9 10**

Overall how do you feel today? **1 2 3 4 5 6 7**

Please indicate below where you are experiencing pain.



COMPLAINT (S): list in order of severity

1. Date when symptoms first appeared: _____

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Constant | <input type="checkbox"/> Frequent 75% | <input type="checkbox"/> Intermittent 50% |
| <input type="checkbox"/> Occasional 25% | <input type="checkbox"/> Rare 10% | |

Describe any related accidents or falls:

What makes symptoms increase? _____

What gives relief? _____

Type of Pain

- | | | | |
|------------------------------------|-------------------------------|--------------------------------------|----------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull | <input type="checkbox"/> Aching | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Numb | <input type="checkbox"/> Other _____ | |

Does the pain radiate? NO YES

Where to ? _____

How bad is the pain? (1 no pain – 10 unbearable)

1 2 3 4 5 6 7 8 9 10

Does this interfere with: Work Sleep Activities

What medications have you taken for this condition?

2. Date when symptoms first appeared: _____

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Constant | <input type="checkbox"/> Frequent 75% | <input type="checkbox"/> Intermittent 50% |
| <input type="checkbox"/> Occasional 25% | <input type="checkbox"/> Rare 10% | |

Describe any related accidents or falls:

What makes symptoms increase? _____

What gives relief? _____

Type of Pain

- | | | | |
|------------------------------------|-------------------------------|--------------------------------------|----------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull | <input type="checkbox"/> Aching | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Numb | <input type="checkbox"/> Other _____ | |

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