

CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID# _____

Patient Name _____

Cell Phone (____) _____ Home Phone (____) _____

Best time to reach you _____

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birth Date _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Spouse's Employer _____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

HEALTH HISTORY

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

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

Date of last: Physical Exam _____ Spinal Exam _____

Blood Test _____ Urine Test _____

Spinal X-Ray _____ Chest X-Ray _____

Dental X-Ray _____ MRI _____

CT-Scan _____ Bone Scan _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis
<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker
<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems
<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis

Exercise ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Work Activity ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Habits ☐ Smoker Packs a day _____

☐ Alcohol Drinks a day _____

☐ Coffee/Caffeine Drinks Cups a day _____

☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had and when

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____

PATIENT CONDITION

Reason for Visit? _____

When did your symptoms appear? _____

Is this condition progressively getting worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

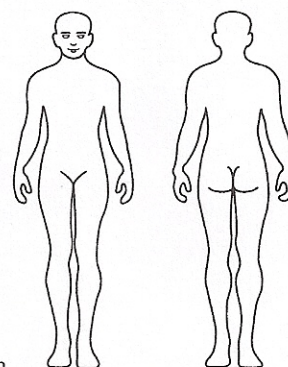
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



MEDICATIONS

ALLERGIES

VITAMINS / HERBS / MINERALS

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name & Phone _____	_____	_____