Chiropractic Registration & History

< PATIENT INFORMATION >

Date ______________________________

Patient (Last Name)______________________________

Name (First Name)______________________________

Address ______________________________

City ______________________________

State ______________ Zip code ______________

Email ______________________________

Sex ☐ M ☐ F ☐ O

Age __________ Birthdate______________

Marital Status

☐ Single ☐ Married ☐ Minor

☐ Other ______________________________

Spouse's Name ______________________________

Spouse's Birthdate ______________________________

< PHONE NUMBERS >

Home Phone ______________________________

Cell Phone ______________________________

Best time to reach you ______________________________

In Case of Emergency, Contact

Name ______________________________

Relationship ______________________________

Cell Phone ______________________________

Work Phone ______________________________

< OTHER INFORMATION >

Occupation/ School ______________________________

Occupation/ School Phone ______________________________

Occupation/ School Address ______________________________

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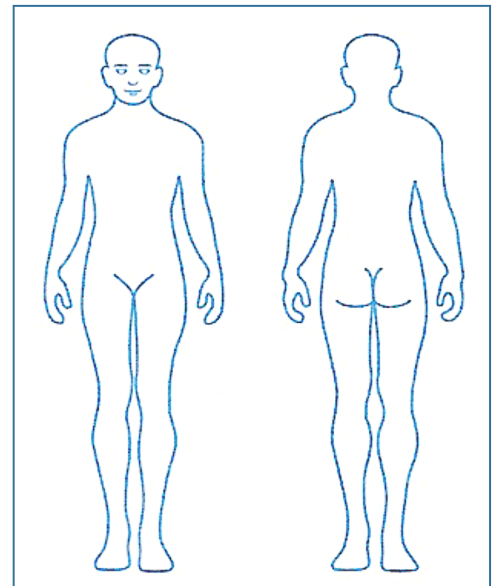
< HOW DID YOU FIND OUT ABOUT OUR OFFICE? >

☐ Ads ☐ Web Searching ☐ Referral - Whom may we thank for referring you? : ______________ ☐ Other

< PATIENT CONDITION >



- Reason for Visit ______________________________
- When did your symptoms appear? ______________________________
- Is this condition getting progressively worse?

  ☐ Yes ☐ No ☐ Unknown

- Mark an "X" on the picture where you continue to have pain and symptoms
- Rate the severity of your pain on a scale from 1 (least pain) to 10 (sever pain) _____
- Type of Pain

  ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching

  ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramping ☐ Stiffness

  ☐ Swelling ☐ Other ______________________________

- Is it constant or does it come and go? ______________________________
- Does it interfere with your

  ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other

- Activities or movements that are painful to perform

  ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

< HEALTH HISTORY >

- **What treatment have you already received for your condition?**

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Care ☐ Other ____________________ ☐ None

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

____

- **Date of Last:**

☐ Physical Exam ______________ ☐ Spinal X-ray ________________ ☐ Blood Test _______________

☐ Spinal Exam ________________ ☐ Chest X-ray ________________ ☐ Urine Test _______________

☐ Dental X-ray _______________ ☐ MRI, CT scan, Bone Scan ________________ ☐ Other ____________________

- **Place a mark on “Yes” or “No” to indicate if you have had any of the following:**

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Polio	☐ Yes	☐ No
Allergy	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Tumor, Growth	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Fractures	☐ Yes	☐ No	Parkinson’s disease	☐ Yes	☐ No	Other ______________________		
Glaucoma	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	______________________		

EXERCISE

☐ None ☐ Moderate ☐ Daily ☐ Heavy

___________days / week

WORK ACTIVITY

☐ Light Labor ☐ Standing

☐ Heavy Labor ☐ Sitting

PREGNANCY

☐ Pregnant ☐ No

* Due Date: _______________

HABITS

☐ Smoking : ________________Packs / Day ☐ Coffee/Caffein Drinks : _______________Cups / Day

☐ Alcohol : _________________Drinks / Week ☐ High Stress Level : Reason ______________________________

INJURIES/ SERGERIES

- **Please describe any experiences with falls, head injuries, bone fractures, dislocations, or surgeries.**

- ____ Date _____________

- ____ Date_____________

MEDICATIONS

____

____

____

(Pharmacy Name/ Phone)

ALLERGIES

____

____

____

VITAMINS/ HERBS/ MINERALS

____

____

____