REGISTRATION AND HISTORY

Date: _____

PATIENT INFORMATION

NAME_____
FIRST MIDDLE LAST

ADDRESS_____APT #_____

_____
CITY STATE ZIP

HOME PHONE #_____ CELL PHONE #_____

E-MAIL ADDRESS_____

SEX ☐ M ☐ F BIRTHDATE_____ AGE_____ SOCIAL SECURITY #_____-_____-_____
MM/DD/YYYY

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPERATED ☐ DIVORCED

OCCUPATION_____EMPLOYER_____☐ FULL-TIME ☐ PART-TIME

EMPLOYER ADDRESS_____

_____
CITY STATE ZIP

EMPLOYER PHONE_____

SPOUSE'S NAME_____

IN CASE OF EMERGENCY, CONTACT

NAME_____RELATIONSHIP_____

HOME PHONE_____ CELL_____

CURRENT HEALTH CONDITION

Reason for visit_____

When did your symptoms begin?_____

Has this condition occurred before? ☐ No ☐ Yes, when?_____

Has this condition changed since it began? ☐ Same ☐ Better ☐ Worse ☐ Other_____

Rate the severity of your symptoms on a scale from 0 (no pain) to 10 (worst pain)_____

Type of pain? ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps
☐ Stiffness ☐ Swelling ☐ Other_____

How often do your symptoms occur? ☐ Constant ☐ Comes and goes, how often & how long?_____

Is this condition due to an accident? ☐ No ☐ Yes, Date_____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other_____

To who have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Worker Comp
☐ Other_____

Attorney Name (if applicable)_____

What treatment have you already received for this condition? ☐ None ☐ Chiropractic ☐ Physical Therapy ☐ Surgery
☐ Medications_____
☐ Other_____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Living ☐ Recreation ☐ Other_____

Which activities or movements are painful to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down
Please list any others: _____

Is there anything that helps your condition? _____

Since your symptoms began, have you had any change in ☐ Bowel Function ☐ Bladder Function ☐ Sexual Function ☐ None

HEALTH HISTORY

Name and address of your Primary Care Physician (Doctor) _____

_____
ADDRESS CITY STATE ZIP

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_____

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

AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Growths	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	♂Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other_____	
Bronchitis	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	_____	
Bulimia	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No	_____	
Cancer	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No		
Cataracts	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Migraine Headache	☐ Yes ☐ No	Stroke	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	♀Miscarriage	☐ Yes ☐ No				
Diabetes	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No				

Exercise	Work Activity	Habits	
☐ None	☐ Sitting	☐ Smoking	Packs/Day_____How Long?_____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week_____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day_____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason_____

How many children do you have? _____ ☐ None

♀**Are you pregnant?** ☐ No, Date of last Menstrual Period_____ ☐ Yes, Due Date_____

Would you like someone to be in the room with you during treatment? ☐ Yes ☐ No

Injuries/Surgeries you have had:	Description	Date
Falls		
Head Injuries		
Broken Bones		
Auto Accidents		
Surgeries		

Are you taking any Medication(s)? ☐ No ☐ Yes, please list medication and what condition they are for _____

_____

Have you ever taken any medications for a prolonged period? ☐ No ☐ Yes, please list medication _____

_____

Do you have any Allergies? ☐ No ☐ Yes, please list them_____

Are you taking any Vitamins/Herbs/Minerals? ☐ No ☐ Yes, please list them with frequency _____

_____

Are you right or left handed?_____

Have you ever been hospitalized? ☐ No ☐ Yes, When? For What? How Long? _____