PATIENT REGISTRATION AND HISTORY

Complete ALL portions of this form. Please Print Clearly.

IF THIS VISIT IS DUE TO A RECENT MOTOR VEHICLE COLLISION OR WORK INJURY,
**** * * * * * PLEASE STOP HERE AND NOTIFY RECEPTION. * * * * * ****

Purpose of this appointment _____

How did you hear about us? ❒ Live nearby ❒ Phone Book ❒ Internet ❒ Promotion other_____
❒ Referred by_____

➢ Patient Information ➢

Patient's Name _____ **Today's Date** _____
Address _____ Home Phone _____
City _____ State _____ Zip _____ Cell Phone _____
Age_____ Birth Date_____ ❒ Male ❒ Female e-mail _____
Marital Status: ❒ Single ❒ Married ❒ Widowed ❒ Sep ❒ Div Ages of Children _____, _____, _____, _____

Occupation _____ Work #_____ ext _____
Employer _____ How long? _____ SS #_____
❒ Full Time ❒ Part Time ❒ Hours/week _____ Driver's License #_____

Spouse's Name _____
Occupation _____ Work #_____ ext _____
Employer _____ Cell Phone _____

Person to contact in case of emergency other than the above Home Phone _____
Name _____ Relationship _____ Work Phone _____

❒ **The patient is a minor** and I am his/her legal guardian. Permission is herewith given by me to the practitioners of this clinic, and whomever they may designate, to examine and render care to the above named patient.

_____	_____	_____	_____
Print Name	Relationship	Signature	Date

➢ Method of Payment ➢

Who is responsible for this account? _____ Method: ❒ Insurance ❒ Personal Payment
Name of Insured _____ Relationship to patient:_____
Name of Primary Insurance Co_____ Plan Name: _____
Billing Address_____ Policy/Group #_____
City_____ State____ Zip _____ Insured's ID #: _____
Phone _____ ext_____ Effective Date of Insurance: _____/_____/_____
Insured's Employer: _____ Insured's Birth date: _____/_____/_____

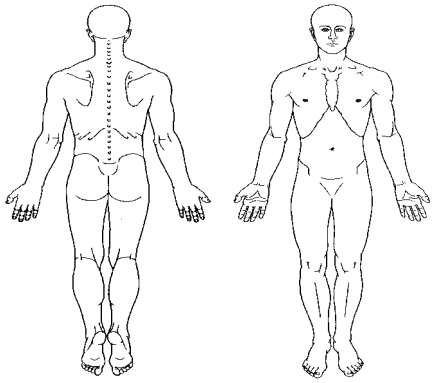
Name of Secondary Insurance Co _____ Plan Name: _____
Name of Insured _____ Policy/Group #_____
List other sources of insurance: (union, school, etc.)_____

Clinic Policy Requires that Payment Arrangements be Made on the First Visit

List your health concerns <u>in order of importance</u>:

Complaint	Rate Severity 1 to 10 At Best - At Worst	Date of Most Recent Onset
1) _____	_____to_____	_____
2) _____	_____to_____	_____
3) _____	_____to_____	_____
4) _____	_____to_____	_____

Please <u>draw in</u> areas of complaint.
Do not just circle or "X" areas.



History of primary complaint:

Describe what **#1** is like (sharp, dull, shooting, tingling, numb, etc.):

_____

Did this result from a ❒ recent or ❒ previous injury or trauma? ❒ Y ❒ N

If **yes**, what occurred? _____

If **no**, how do you think this came about? _____

Have you had this or a similar problem before? ❒ Y ❒ N If yes, when was the very first time? _____

Is this condition getting worse? ❒ Yes ❒ No ❒ Staying the same ❒ Comes and goes Worse in ❒ AM ❒ PM

Does it travel from one area to another? ❒ Yes ❒ No Describe _____

What initiates it? _____ What makes it worse? _____

What percent of the time does it bother? _____ % How long does it last at a given time? _____

Does it affect your: ❒ Work ❒ Sleep ❒ Daily Routine ❒ Relationships ❒ Recreation Other _____

Are you able to obtain any relief on your own? ❒ Yes ❒ No By what means? _____

Have you been treated by another for this condition? ❒ Yes ❒ No Date Last Treated _____

If yes, name of doctor/health care facility: _____

What was done? ❒ Medication ❒ Surgery ❒ Chiropractic ❒ Physical Therapy Other _____

Duration of care _____ Frequency of care _____ Results: ❒ Good ❒ Fair ❒ Poor

Is there any family history of this? ❒ Mother ❒ Father ❒ Sister ❒ Brother ❒ Children ❒ Grandparent

Activities and Lifestyle: Do you consume just water? ❒ Yes ❒ No _____glasses/day

Work activity: ❒ Mainly Sitting ❒ Mainly Standing/Walking ❒ Light Labor ❒ Heavy Labor _____

Regular exercise: ❒ None ❒ Light ❒ Moderate ❒ Heavy ❒ ____ times weekly

Rest: Do you wake up refreshed? ❒ Yes ❒ No In what sleep position do you typically wake up? ❒ Back ❒ Side ❒ Stomach

Coffee/Caffeine consumption: ❒ Never ❒ Not for ____years ❒ ____cups per day

Alcohol consumption: ❒ Never ❒ Not for ____years ❒ ____drinks per day/week

Tobacco consumption: ❒ Never ❒ Not for ____years ❒ ____packs per day For how long?_____

Do you consume microwaved food or beverages? ❒ Yes ❒ No How many bowel movements each day?_____

Are you on any particular diet? ❒ Yes ❒ No Describe _____

What vitamins/minerals/herbs do you take? _____

List any known allergies / sensitivities _____

Current medications (including non-prescription):

Name of Medication	Reason for taking	When you began taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Injuries and Surgeries:	Description	Dates
Sports / Work / Auto Accidents	_____	_____
Falls	_____	_____
Head Injuries	_____	_____
Fractures / Dislocations	_____	_____
Surgeries	_____	_____

Your Health History (circle "**C**" if the problem is a **current** one and "**P**" if you've only had it in the **past**)

General	Muscles & Joints	Eyes, Ears, Nose & Throat	Gastrointestinal
C P Anemia	C P Arthritis	C P Hearing Loss	C P Colon Problems
C P Allergy shots	C P Bursitis	C P Ear-ache / pain	C P Constipation
C P Convulsions .	C P Neck Pain / Stiffness .	C P Cataracts / Glaucoma	C P Diarrhea
C P Dizziness .	C P Shoulder Pain	C P Failing Vision	C P Gall Bladder
C P Fainting .	C P Mid-back Pain	C P Nosebleeds	C P Hemorrhoids
C P Fatigue .	C P Low Back Pain/Stiff	C P Sinus Infections	C P Hernia
C P Headaches .	C P Spinal Curvature	C P Strep Throat	C P Liver Problems
C P Migraines .	C P Herniated Disc	C P Thyroid Problems	C P Nausea / Vomiting
C P Sudden Weight Loss	C P Osteoporosis	C P Goiter	C P Poor Digestion

Respiratory	Pain or Numbness in:	Skin Problems	Other
C P Asthma	C P Head / Face / Throat .	C P Acne	C P Cancer / Malignancy
C P Bronchitis	C P Shoulders / Arms	C P Bleeding Disorders	C P Diabetes .
C P Chest Pain	C P Elbows / Hands	C P Bruise Easily	C P Chemical Dependency
C P Chronic Cough	C P Fingers / Toes	C P Allergic Reactions	C P Chicken Pox
C P Emphysema	C P Hips / Legs / Knees	C P Skin Rash or Hives	C P Measles
C P Spitting up Blood	C P Ankles / Feet	C P Surface Scars	C P Mononucleosis
C P Pneumonia or TB	C P Prosthesis	C P Deep Scars	C P Mumps
			C P Polio
Cardio-Vascular	**Genito-Urinary**	**Neurological**	C P Rheumatic Fever
C P Heart Disease .	C P Bedwetting	C P Alcoholism	C P Scarlet Fever
C P High B/P .	C P Frequent Urination	C P Alzheimer's	C P Typhoid Fever
C P Low B/P	C P Painful Urination	C P Epilepsy	C P Whooping Cough
C P Rapid Heart Beat	C P Gout	C P Parkinson's	C P Multiple Sclerosis
C P Slow Heart Beat	C P Kidney Infection	C P Seizures	C P Sexual Transmitted Disease
C P Arrhythmia .	C P Kidney Stones	C P Stroke .	C P HIV Positive
C P High Cholesterol .	C P Prostate Trouble	C P Trouble Sleeping	C P Psychiatric Care
C P Pacemaker	C P Swelling of Ankles	C P Unable to Relax	C P Tumors / Growths / Cysts

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For Women Only		
C P Cramps or Backache w/cycle	C P Pain with intercourse	C P Facial Hair / Thinning Hair
C P Irregular Cycle Length	C P Unable to Conceive	C P Breast Implants
C P Scanty or Excess Flow	C P Miscarriage(s)	C P Hysterectomy
C P Breast or Ovarian Cysts	C P Pelvic Inflammatory Disease	C P Chemical Contraception
	C P PMS / Painful Menstruation	C P Menopausal

Are you pregnant at this time? ❒ Yes ❒ No ❒ Possibly Date last cycle started _____

Your Family History (some health problems result from familial tendencies)

Family Member	Past & Current Illnesses	Current Age	Cause of Death or N/A
Mother	_____	_____	_____
Father	_____	_____	_____
Sister(s)	_____	_____	_____
Brother(s)	_____	_____	_____

Have you had chiropractic care before? ❒ Yes ❒ No If yes, was your experience: ❒ Good ❒ Fair ❒ Poor

Duration of care _____ Frequency of care _____ Preferred style? ❒ Manipulation ❒ Low force

Signature of Patient / Legal Guardian _____ Date _____