Chiropractic
Health History & Registration

Patient Information
Date _____
Drivers License # _____
First Name:_____ Last Name:_____
Address_____
_____
City _____
State _____ Zip Code_____
E-mail _____
Sex M F Age _____ Birth date ____/____/_____

Employment Information
Occupation _____
Employer/School _____
Work Phone (_____)_____ext._____

Phone Numbers
Home (_____)_____ Cell (_____)_____
Best time and place to reach you _____

In Case of Emergency, Contact…
Name _____ Relationship _____
Home (_____)_____ Work/Cell (_____)_____

How did you hear about our office? _____

Patient Condition
Reason for Visit _____

When did your symptoms appear and what happened to cause them?_____
_____
Is this condition getting progressively worse? Yes No Unknown
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 Recreation Daily Routine

Activities or movements which are painful to perform:

Sitting Standing Walking Bending Lying Down

What Treatment have you already received for your condition: Medication Surgery

Physical Therapy Chiropractic Services None Other: _____

Previous injuries or accidents that could be related to your current symptoms.

Previous injuries or accidents that could be related to your current symptoms.

_____
_____
_____

Is there any other <u>Injuries</u>, <u>Surgeries</u>, or <u>Conditions</u> that I should know about?

(Description) ***(Date)***

Head Injuries _____ _____
Broken Bone _____ _____
Dislocations _____ _____
Surgeries _____ _____
Other _____ _____

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

AIDS/HIV Yes No Alcoholism Yes No
Anemia Yes No Anorexia Yes No
Appendicitis Yes No Arthritis Yes No
Asthma Yes No Bleeding Disorders Yes No
Breast Lump Yes No Bronchitis Yes No
Bulimia Yes No Cancer Yes No
Chemical Dependency Yes No Diabetes Yes No
Emphysema Yes No Epilepsy Yes No
Fractures Yes No Gout Yes No
Heart Disease Yes No Hepatitis Yes No
Herniated Disk Yes No Migraine Headaches Yes No
Multiple Sclerosis Yes No Osteoporosis Yes No
Pacemaker Yes No Parkinson's Disease Yes No
Pinched Nerve Yes No Polio Yes No
Prostate Problems Yes No Prosthesis Yes No
Psychiatric Care Yes No Rheumatoid Arthritis Yes No
Stroke Yes No Suicide Attempt Yes No
Thyroid Problems Yes No Tumors, Growths Yes No
Ulcers Yes No
Others:_____

Exercise: **Work Activity:** **Habits**:

None Sitting Smoking Packs/Day: _____
Moderate Standing Alcohol Drinks/week: _____
Daily Light Labor Coffee/Caffeine, Cups/Day: _____
Heavy Heavy Labor High Stess Level, Reason: _____

Are you pregnant? Yes No Due Date: _____
Are your symptoms related to, or caused by an Automobile Accident? Yes No Date: _____