PATIENT REGISTRATION

Patient Information

(Please Print)
Patient Name______________________________ Date:_______

Email____

Address____

City_______________________ State_____ Zip____________

Home phone______________Cell phone_________________

SS#________________ DOB_________________Age______

Married ☐ Single ☐ Divorced ☐ Widowed ☐

Male / Female Your Occupation ___________________

Employer____

Employer Address ___________________________________

Employer Phone ____________________________________

Spouse's Name _____________________________________

Spouse's DOB____________ SS#_____________________

Spouse's Employer___________________________________

Whom may we thank for referring you ?_________________

Have you received chiropractic care before? ______________

Emergency Contact:__________________________________

Emergency Contact Phone:_____________________________

Goals for Care

People see Chiropractors for a variety of different reasons. Some go for relief of pain, some to correct the cause, and others for prevention. Your doctor will weigh your needs and desires when recommending your health program. Please check the type of care desired so we may be guided by your wishes whenever possible.

☐ Relief Care - Symptomatic relief of pain /discomfort

☐ Corrective Care - Correcting, relieving, stabilizing

☐ Prevention - Maintaining the body to the highest

☐ I want the doctor to select the type of care appropriate for my condition.

List any other Doctors you have consulted for this condition:

____

Primary Physician ___________________________________

Primary Physician Phone # ____________________________

Insurance Information

Who is responsible for this account?______________________

Relationship to patient ________________________________

Primary Insurance Company____________________________

Policy #___________________ Group #_________________

Secondary Insurance Company__________________________

Policy # ___________________ Group #_________________

Subscriber's Name____________________________________

Birth Date___________________ SS#___________________

Accident Information

Is condition due to an accident? Yes ☐ No ☐ Date ________

Type of accident ☐ Auto ☐ Work ☐ Home

To whom have you made a report of your accident?

☐ Auto insurance ☐ Employer ☐ Worker Comp.

Attorney Name (if applicable)__________________________

Patient Condition

What is your primary reason for seeking care today?

____

Have you missed any work due to this condition? **Yes / No**

What treatment have you received for this condition?

☐ Physical Therapy ☐ Chiropractic Services ☐ Surgery
☐ Medication ☐ None ☐ Other

Name and Phone # of Dr. treating you for this condition.

____

Date of last:
Physical exam___________________

Spinal X-Ray ___________________

Blood Test _____________________

Urine Test _____________________

MRI,CT Scan___________________

PATIENT REGISTRATION

List all prescription and non – prescription drugs you are currently using : ________________________________

____

List any surgeries you have had : ________________

____

List any past broken or fractured bones: ____________

____

Have you ever suffered from:

☐ Dizziness ☐ High Blood Pressure ☐ Numbness
☐ Arteriolosclerosis ☐ Tuberculosis ☐ Sinus Trouble
☐ Anemia ☐ Headache ☐ Asthma
☐ Bleeding Disorder ☐ Heart Disease ☐ Cancer
☐ Arthritis ☐ Diabetes ☐ Stroke

Do you exercise? ☐ No ☐ Yes

What type and frequency of exercise?

____

____

What activities does your job entail?

☐ Sitting ☐ Standing ☐ Lifting
☐ Computer use ☐ Repetitive motions ☐ Twisting

How do you rate your diet? (1being excellent and 10 poor)

______

Do you take vitamins? ☐ No ☐ Yes

Would you say your sleep is : Good ☐ Fair ☐ Bad ☐

Your sleeping position is: Back ☐ Side ☐ Stomach ☐

Do you Smoke? No / Yes How Much? ____________

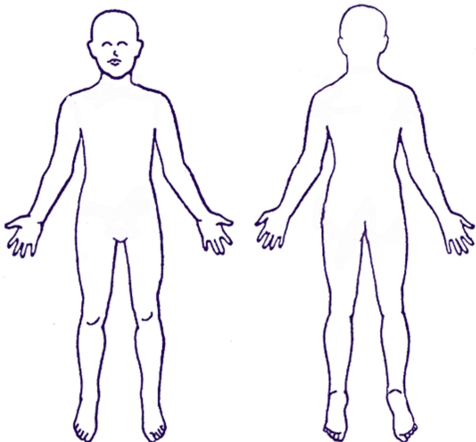
How would you rate your stress levels? (1 = excellent 10 = poor)

Home: **1 2 3 4 5 6 7 8 9 10**

Work: **1 2 3 4 5 6 7 8 9 10**

Overall how do you feel today? **1 2 3 4 5 6 7**

Please indicate below where you are experiencing pain.



COMPLAINT (S): list in order of severity

____

____

1. Date when symptoms first appeared: ____________

☐ Constant ☐ Frequent 75% ☐ Intermittent 50%
☐ Occasional 25% ☐ Rare 10%

Describe any related accidents or falls:

____

____

What makes symptoms increase? ____________

What gives relief? ____________

Type of Pain

☐ Sharp ☐ Dull ☐ Aching ☐ Burning
☐ Throbbing ☐ Numb ☐ Other ____________

Does the pain radiate? NO ☐ YES ☐

Where to ? ________________________________

How bad is the pain? (1 no pain – 10 unbearable)

1 2 3 4 5 6 7 8 9 10

Does this interfere with: Work ☐ Sleep ☐ Activities ☐

What medications have you taken for this condition?

____

____

2. Date when symptoms first appeared: ____________

☐ Constant ☐ Frequent 75% ☐ Intermittent 50%
☐ Occasional 25% ☐ Rare 10%

Describe any related accidents or falls:

____

____

What makes symptoms increase? ____________

What gives relief? ____________

Type of Pain

☐ Sharp ☐ Dull ☐ Aching ☐ Burning
☐ Throbbing ☐ Numb ☐ Other ____________

Does the pain radiate? NO ☐ YES ☐

Where to ? ________________________________

How bad is the pain? (1 no pain – 10 unbearable)

1 2 3 4 5 6 7 8 9 10

Does this interfere with: Work ☐ Sleep ☐ Activities ☐

What medications have you taken for this condition?

____

____