

# Chiropractic Registration and History

## Patient Information

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_

\_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  
 Minor  Separated  Divorced

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

\_\_\_\_\_

Employer/School Phone \_\_\_\_\_

\_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Phone Numbers

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

## IN CASE OF AN EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## Patient Condition

Medications

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Vitamins/Herbs/Minerals

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Pharmacy Phone \_\_\_\_\_

## Accident Information

Is condition due to an accident?

Yes  No Date \_\_\_\_\_

Type of Accident:  Auto

Work  Home  Other

To whom have you made a report of your accident?

Employer

Auto Insurance

Worker Comp

Other

Attorney Name \_\_\_\_\_

(if applicable)

Reason for visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

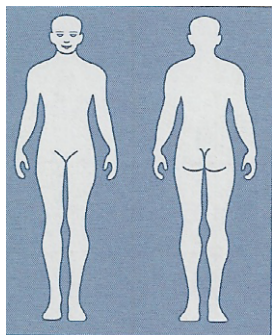
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

How often do you have this pain? \_\_\_\_\_

Is it constant does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Mark an X on the picture where you continue to have pain, numbness, or tingling.



## Recent History:

Check if you are experiencing any of the following:

- Numbness or other sensory complaints
- Loss of consciousness
- Double vision
- Blurred vision
- Tinnitus (ringing in ears)
- Speech problems
- Clumsiness
- Memory loss
- Personality changes
- Fever
- Diarrhea
- Muscle, tendon or ligament problems
- Does your pain wake you up at night?
- Unusual bleeding or discharge
- Obvious change in a wart/mole

- Loss of strength
- Head Trauma
- Skin, hair or nail problems
- Mouth and/or throat problems
- Nose and/or sinus problems
- Ear problems
- Chest or lung (breathing) problems
- Lymph node problems
- Digestive problems
- Physically Abused
- Bone or joint diseases
- Losing weight without trying
- Sore that doesn't heal
- Indigestion or difficulty swallowing
- Nagging cough or hoarseness

## EXERCISE

- None
- Moderate
- Daily
- Heavy

## WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

## HABITS

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Packs/Day \_\_\_\_\_

Drinks/Week \_\_\_\_\_

Cups/Day \_\_\_\_\_

Reason \_\_\_\_\_

# Health History

Injuries/Surgeries you have had

Description

Date

Falls

Head Injuries

Broken Bones

Dislocations

Surgeries

_____	_____
_____	_____
_____	_____
_____	_____

What treatment have you already received for your condition?  Medications

- Surgery  
  Physical Therapy  
  Chiropractic Services  
  None  
 Other

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 \_\_\_\_\_

Currently pregnant? \_\_\_\_\_

List any diseases that you have had in the past \_\_\_\_\_

List any conditions diagnosed \_\_\_\_\_

Hospitalization not related to surgery: \_\_\_\_\_

Check if you have ever had any of the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> AIDS/HIV                 | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Partial/Complete Paralysis |
| <input type="checkbox"/> Appendicitis             | <input type="checkbox"/> Hernia                  | <input type="checkbox"/> Pinched Nerve              |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Herniated Disk          | <input type="checkbox"/> Polio                      |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Prosthesis                 |
| <input type="checkbox"/> Bleeding Disorders       | <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Rheumatoid Arthritis       |
| <input type="checkbox"/> Breast Lump              | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Breast Removal           | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Bronchitis               | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> Slipped Disk               |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Loss of Bowel Control   | <input type="checkbox"/> Spinal Surgery             |
| <input type="checkbox"/> Carotid Artery Surgery   | <input type="checkbox"/> Migraine Headaches      | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Childhood Accident/Falls | <input type="checkbox"/> Miscarriage             | <input type="checkbox"/> Temporary loss of vision   |
| <input type="checkbox"/> Claustrophobia           | <input type="checkbox"/> Multiple Sclerosis      | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Drop Attacks             | <input type="checkbox"/> Nervous System Disorder | <input type="checkbox"/> TIAs                       |
| <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Osteoporosis            | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Fractures                | <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Tumors, Growths            |
| <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Parkinson's Disease     | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Goiter                   |  | <input type="checkbox"/> Other _____                |
| <input type="checkbox"/> Hardening Arteries       |  |   |